RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

November 14, 2018

Lakeview Assisted Living, LLC
1100 N Lake Shore Dr
Gladstone, MI 49837

RE: License #: AL210386348
Investigation #: 2018A0221014
Lakeview Assisted Living IV, LLC

Dear Lakeview Assisted Living, LLC:

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 (906) 226-4171.

Sincerely,

Theresa Norton, Licensing Consultant
Bureau of Community and Health Systems
234 West Baraga
Marquette, MI 49855
(906) 280-2519

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL210386348
Investigation #:	2018A0221014
Complaint Receipt Date:	09/25/2018
Investigation Initiation Date:	09/26/2018
Report Due Date:	11/24/2018
Licensee Name:	Lakeview Assisted Living, LLC
Licensee Address:	1100 N Lake Shore Dr Gladstone, MI 49837
Licensee Telephone #:	(906) 428-7000
Administrator:	Daryl Miron
Licensee Designee:	Daryl Miron
Name of Facility:	Lakeview Assisted Living IV, LLC
Facility Address:	1100 N. Lake Shore Drive Gladstone, MI 49837
Facility Telephone #:	(906) 428-7000
Original Issuance Date:	12/21/2017
License **Status:**	REGULAR
Effective Date:	06/21/2018
Expiration Date:	06/20/2020
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED AGED

	TRAUMATICALLY BRAIN INJURED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident eloped out of window in 06/2018. There is no alarm system to alert staff if a memory care resident elopes.	Yes
Facility kicked the resident out within 48 hours with no place to go.	Yes
Resident A had been repeatedly overdosed.	Yes
Additional Findings	Yes

III. METHODOLOGY

09/25/2018	Special Investigation Intake 2018A0221014
09/26/2018	APS Referral Email to Shawn Maki - Delta County APS worker.
09/26/2018	Special Investigation Initiated - Telephone Phone call to Complainant.
09/26/2018	Inspection Completed On-site
09/26/2018	Contact - Face to Face Interview with Administrator Amy Cook and on staff R.N Christie Mathias.
09/26/2018	Contact - Document Received Resident A's file and Medication Administration Record.
09/26/2018	Contact - Telephone call received Phone call from Licensee Daryl Miron.
09/27/2018	Exit Conference Exit interview with Licensee Daryl Miron.

ALLEGATION: Resident eloped out of a window in 06/2018. There is no alarm system or fence or anything to alert staff if a memory care resident elopes.

INVESTIGATION: On 09/24/2018 a complaint was received in this office. The complainant stated that Resident A has Alzheimer's Disease and had escaped from the 'memory care unit' of Lakeview Assisted living around the "3rd week of June". The complainant further stated in June, Resident A was seen by a passerby on the highway, looking dazed and confused, and then alerted the authorities. The complainant stated Resident A had walked to the family home (which is approximately ¼ mile from the facility) arriving at approximately 1:30AM. Resident A was brought back to the facility.

The complainant further stated that no staff of the home knew Resident A had left the facility. The complainant also stated a concern there were no "sensing mechanism around the memory care unit".

An unannounced inspection was completed at the facility on 09/26/2018. Interviews were conducted with Administrator Amy Cook and on staff R.N. Christy Mathias. Resident A's file, medication record, and staff communication logs were reviewed. A physical inspection was also completed in Resident A's room. No incident report was completed for this incident (See findings below).

Ms. Cook explained that on 06/23/2018, at approximately 1:00AM, the Gladstone Public Safety and the Michigan State Police arrived at the facility inquiring if there was a missing person from the facility, as they had received a call concerning a "disorientated elderly person" spotted near the facility. The staff on duty checked all rooms and discovered that Resident A was not in his room in the memory care unit.

At approximately 1:30AM, Resident A's DPOA (designated power of attorney) had returned Resident A to the facility. The staff assessed for any injury, and Resident A was found to be physically fine and Resident A was returned to his room. A staff was assigned exclusively for Resident A for the remainder of the night, and 15-minute checks were instated for all residents in the memory from 06/23/2018 and is now a current practice.

R.N. Mathias produced the staff communication log for 06/23/2018. R.N. Mathias stated staff do "rounds" to check on residents during sleeping hours every 2 hours, prior to 06/23/2018. The staff communication log indicates that at 11:00PM on 06/22/2018, Resident A was observed sleeping in his room. At 1:00AM on 06/23/2018, when the check was completed to search for any missing resident, staff discovered Resident A's bed was arranged to look like he was sleeping in bed with pillows arranged under the covers to appear he was in bed and sleeping. Further examination of the room showed the window was closed and the screen was replaced in the outer window.

On the 09/26/2018 inspection, this consultant observed Resident A's previous room (Resident A was discharged on 08/02/2018). The window is approximately 2 feet wide by 3 feet tall and was easily opened and no alarm or sensor was present on the window. All of the exit doors have delayed exit alarms and key codes are required to enter and exit the memory care unit.

Ms. Cook stated Resident A had attempted to elope one other time (date unknown) from the facility by following visitors out the coded front door. Resident A was followed by staff into the parking lot and successfully led back to the facility.

During the 09/27/2018 exit interview with Licensee Daryl Miron, he acknowledged the findings of this report and stated he has ordered window alarms for all units in the memory care facility. In addition, 15-minute physical checks are conducted on all residents during sleeping hours.

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:	Resident A had a history of attempts to leave the facility. The Licensee failed to protect Resident A by not securing the large, easily openable window and screens of Resident A's memory care unit bedroom.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Facility kicked the resident out within 48 hours with no place to go.

INVESTIGATION: The complainant reports that Resident A was given a 48-hour discharge from Lakeview Assisted Living on 7/02/2018, because Resident A was aggressive. The complainant stated a family member took Resident A to the hospital, but there were no physical issues and the hospital ordered him to return to the facility.

Administrator Cook stated she did give a 'verbal' 48-hour discharge to Resident A's DPOA, 0n 07/02/2018, due to Resident A's disruptive behavior and elopement attempts. Ms. Cook stated she did not give a written discharge summary to the family, nor did she contact this department with the discharge plan.

Ms. Cook stated Resident A had returned to the facility on 07/02/2018 from the hospital (with one on one staff assigned to him). Ms. Cook further stated she and staff contacted several facilities for the family and Resident A was discharged on 08/02/2018 to a more appropriate facility.

Licensee Daryl Miron was informed and acknowledged the need to issue written discharge summaries during the 09/27/2018 exit conference.

APPLICABLE RULE	
R 400.15302	**Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.**
	(5) A licensee who proposes to discharge a resident for any of the reasons listed in subrule (4) of this rule shall take the following steps before discharging the resident: **(a) The licensee shall notify the resident, the resident's designated representative, the responsible agency, and the adult foster care licensing consultant not less than 24 hours before discharge. The notice shall be in writing and shall include all of the following information:** **(i) The reason for the proposed discharge, including the specific nature of the substantial risk.** **(ii) The alternatives to discharge that have been attempted by the licensee.** **(iii) The location to which the resident will be discharged, if known.**
ANALYSIS:	The Licensee gave a verbal 48-hour discharge notice to Resident A's DPOA on 07/02/2018. No written discharge summary was created. This department was not notified of the discharge plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A had been repeatedly overdosed.

INVESTIGATION: The complainant stated Resident A was "overdosed" on medication two times.

Resident A's Medication Administration Record (MAR) was reviewed. R.N. Christy Mathias was interviewed on 09/26/2018. R.N. Mathias stated that on 06/25/2018, Resident A was given his prescribed Ativan (order states Ativan 1mg. 4 times a day

PRN). The Ativan was given on 06/25/2018, due to disruptive behaviors at 8:15AM, 2:15PM, and 4:30PM. There was a question whether the doses between 2:15PM and 4:30PM were too close, making Resident A lethargic. R.N. Mathias stated she called Resident A's physician, Dr. Michael Keeker on 06/25/2018 concerning this issue Dr. Keeker informed R.N. Mathias that the doses should be 4 hours apart. R.N. stated she did not recall another time that Resident A was given the Ativan other than what was prescribed.

The MAR was reviewed and coincided with the 06/25/2018 doses of Ativan given to Resident A. The other days the prescribed Ativan was given at sporadic times, but no more than 4 hours apart for each dose.

The complainant could not remember the dates of when Resident A was "overdosed" at the facility.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Resident A was given Ativan on 06/25/2018 for aggressive behavior. The Ativan was prescribed – 1mg. 4 times a day PRN. There were two doses given within 2 and ½ hours apart. The physician stated the Ativan should be given no more than 4 hours apart.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: No written incident report was written or distributed concerning Resident A's elopement on 06/23/2018.

APPLICABLE RULE	
R 400.15311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and

	the adult foster care licensing division within 48 hours of any of the following: **(c) Incidents that involve any of the following:** **(iii) Attempts at self-inflicted harm or harm to others.**
ANALYSIS:	Resident A eloped out of his bedroom window. No written incident report was created concerning the elopement of Resident A on 06/23/2018. This department did not receive a written report of the incident.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION: No internal or formal incident report was created or documented for the elopement of Resident A on 06/23/2018.

APPLICABLE RULE	
R 400.15311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(6) An accident record or incident report shall be prepared for each accident or incident that involves a resident, staff member, or visitor. "Incident" means a seizure or a highly unusual behavior episode, including a period of absence without prior notice. An accident record or incident report shall include all of the following information: **(a) The name of the person who was involved in the accident or incident.** **(b) The date, hour, place, and cause of the accident or incident.** **(c) The effect of the accident or incident on the person who was involved and the care given.** **(d) The name of the individuals who were notified and the time of notification.** **(e) A statement regarding the extent of the injuries, the treatment ordered, and the disposition of the person who was involved.** **(f) The corrective measures that were taken to prevent the accident or incident from happening again.**

ANALYSIS:	No internal or formal incident report was completed when Resident A eloped on 06/23/2018.
CONCLUSION:	**VIOLATION ESTABLISHED**

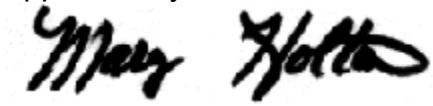
IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend no change to the status of this license.

11/14/2018

Theresa Norton — Date
Licensing Consultant

Approved By:



11/14/2018

Mary E Holton — Date
Area Manager