STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

March 29, 2019

Shawn Phillips
Emerald Meadows
6117 Charlevoix Woods Ct.
Grand Rapids, MI 49546-8505

RE: License #: AH410343036
Investigation #: 2019A1010015
Emerald Meadows

Dear Mr. Phillips:

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 authorized representative and a date.

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,

Lauren Wohlfert

Lauren Wohlfert, Licensing Staff
Bureau of Community and Health Systems
Unit 13, 7th Floor

350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 260-7781

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH410343036
Investigation #:	2019A1010015
Complaint Receipt Date:	02/07/2019
Investigation Initiation Date:	02/11/2019
Report Due Date:	04/09/2019
Licensee Name:	Providence Operations, LLC
Licensee Address:	18601 North Creek Drive Tinley Park, IL 60477
Licensee Telephone #:	(708) 342-8100
Authorized Representative/ Administrator:	Shawn Phillips
Name of Facility:	Emerald Meadows
Facility Address:	6117 Charlevoix Woods Ct. Grand Rapids, MI 49546-8505
Facility Telephone #:	(616) 954-2366
Original Issuance Date:	08/26/2013
License Status:	REGULAR
Effective Date:	03/07/2018
Expiration Date:	03/06/2019
Capacity:	60
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident N exited the facility through an emergency exit. The alarm on the door didn't sound.	No
Additional Findings	Yes

III. METHODOLOGY

02/07/2019	Special Investigation Intake 2019A1010015
02/11/2019	Special Investigation Initiated - Telephone Interviewed complainant by telephone
02/13/2019	Inspection Completed On-site
02/13/2019	Contact - Document Received Received Resident N's service plan
03/29/2019	Exit Conference Completed with authorized representative Shawn Phillips

ALLEGATION:

Resident N exited the facility through an emergency exit. The alarm didn't sound.

INVESTIGATION:

On 2/7/19, the Bureau received this complaint from Adult Protective Services (APS). The complaint was not assigned for APS investigation.

On 2/11/19, I interviewed Kent County Sheriff Deputy Emily Eaton. Deputy Eaton reported she responded to the facility regarding an unrelated issue on 2/6. Deputy Eaton stated when she arrived at the facility, she observed Resident N outside by an emergency exit door. Deputy Eaton said Resident N was wearing shoes, long pants, a long sleeved shirt, and a hooded short sleeve zip up shirt over her long sleeved shirt. Deputy Eaton reported Resident N did not have a coat on. Deputy Eaton said Resident N told her she lived at the facility, however she could not remember how to she got outside. Deputy Eaton explained Resident N reached for the door handle on the right side of the door although the handle was located on the left side. Deputy Eaton reported Resident N complained about being cold.

Deputy Eaton stated Resident N was disoriented and it is unknown how long she was outside. Deputy Eaton reported she entered the facility and located staff. Deputy Eaton said the staff persons she talked to were surprised to learn Resident N got outside. Deputy Eaton explained the emergency exit door Resident N opened and exited through did not alarm to alert staff.

On 2/13/19, I interviewed administrator Shawn Phillips at the facility. Mr. Phillips reported prior to Resident N's elopement on 2/6, she was alert, oriented, and not considered a wonder risk. Mr. Phillips explained Resident N made no prior attempts to elope from the facility. Mr. Phillips said Resident N resides in the general assisted living area and receives little assistance from staff with her activities of daily living (ADLs).

Mr. Phillips stated Resident N primarily stays in her room and only leaves the facility when her family signs her out. Mr. Phillips said Resident N "stays to herself" and prefers to eat meals in her room rather than go to the dining room. Mr. Phillips said staff had no way to predict Resident N would elope from the facility on 2/6 because she had no history of wandering or previous elopement attempts.

Mr. Phillips stated staff do rounds and check on residents every two hours in the general assisted living area. Mr. Phillips reported Resident N did not require additional supervision. Mr. Phillips said after the incident, a wander guard device was placed on Resident N.

Mr. Phillips reported the south east emergency exit door that Resident N used to get outside alarms when opened. Mr. Phillips stated that as a result of the recent ice storms in the area on 2/6 and 2/7, there were likely power surge issues that effected the facility's door alarm systems. Mr. Phillips explained the facility's annual fire inspection with the Bureau of Fire Services (BFS) was completed on 2/5. Mr. Phillips reported the door alarms were tested during the fire inspection and all were in working order.

Mr. Phillips explained staff called Riverside Integrated Systems after they were alerted Resident N got outside. Mr. Phillips reported staff attempted to troubleshoot the door alarm system over the telephone, however the fix was not made over the telephone. Mr. Phillips said Riverside Integrated Systems arrived at the facility on 2/7 to fix the door alarm system. Mr. Phillips reported the door alarm system was fixed on 2/7. Mr. Phillips demonstrated and opened the south east emergency door Resident N exited through. I heard the alarm sound when the door was opened.

Mr. Phillips stated staff saw Resident N in her room on 2/6 at 7:20 pm when rounds were completed. Mr. Phillips reported staff were notified Resident N eloped at 7:58 pm. Mr. Phillips said he talked to Resident N after the incident. Mr. Phillips stated Resident N told him “she was going out” when he questioned her about the incident.

Mr. Phillips provided me with a copy of Resident N’s updated service plan service plan for my review. The *Wandering/Elopement – Supervision* section of the plan read, “Instructions: Provide supervision and redirection to avoid and prevent wandering episodes. If wandering occurs, determine follow-up plan. Status: To receive full supervision and redirection from staff to avoid and prevent wandering episodes.”

Mr. Phillips also provided me with a copy of Resident N’s previous service plan for my review. The plan read Resident N required as needed assistance from staff for bathing, dressing, mobility and walking, oral cares, and toileting. There was no section for supervision as she did not require it prior to the incident.

Mr. Phillips reported care staff persons Nyeasa Calvert, Christina Jones, Kanisha Sanders were working second shift on 2/6 when Resident F exited the facility. Mr. Phillips stated Ms. Sanders is an agency staff person, she is not employed at the facility. Mr. Phillips said he did not have a direct telephone number for Ms. Sanders.

On 2/13/19, I interviewed Resident N at the facility. Resident N was difficult to engage in meaningful conversation. When questioned about the incident, Resident N reported she “was having dinner in the basement and the maintenance man was pounding in the basement.” Resident N said “so I thought I’ll go to my room, but the door was locked.” Resident N stated her room door is not usually locked. Resident N denied ever being stuck outside in the cold.

On 2/19/19, I reviewed the facility file and verified there was a BFS annual inspection on 2/5. There was nothing in the BFS report regarding the emergency exit door alarms not sounding when opened.

On 2/19/19, I attempted to interview Ms. Calvert by telephone. A prompt said, “this number is not in service.”

I left several telephone messages for Ms. Jones and requested a call back. As of 2/22, I have not received a return telephone call.

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following:

	(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.
ANALYSIS:	The interview with Mr. Phillips, along review of Resident N's previous service plan, revealed she had no prior history of leaving the facility without signing in or out with her daughter. As a result, staff at the facility had no way to anticipate Resident N's decision to leave the facility without alerting staff. After the incident on 2/6, the facility instituted additional measures to monitor Resident N.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDING:

On 2/13/19, I observed a bed cane assistive device unsecured between Resident N's mattress and box spring. Mr. Phillips reported he was not aware Resident N had the device.

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following: **(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.**
ANALYSIS:	On 2/13, I observed a bed cane assistive device located between the mattress and box spring on Resident N's bed. The device was unsecured could be moved easily causing areas of entrapment and strangulation risks. These devices are prohibited due to the safety risk they pose to residents.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Special Investigation Report (SIR) 2018A1010006 dated 1/2/18 and SIR 2017A1010056 dated 8/3/17**

Resident N's incident report read she exited the building and was observed standing outside alone on 2/6 at 8:00 pm. I did not receive the incident report until 2/9 at 10:23 pm.

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, accidents, elopement.**
	(3) The home shall report an incident/accident to the department within 48 hours of the occurrence. The incident or accidents shall be immediately reported verbally or in writing to the resident's authorized representative, if any, and the resident's physician.
For Reference: R 325.1901	**Definitions**
	(17) "Reportable incident/accident means an intentional or unintentional event in which a resident suffers harm or is at risk of more than minimal harm, such as, but not limited to, abuse, neglect, exploitation, or unnatural death.
ANALYSIS:	The facility did not report Resident N's elopement from the facility within the required 48 hour reporting time frame.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED SIR 2017A1010039 dated 6/1/17**

I shared the findings of this report with licensee authorized representative Shawn Phillips by telephone on 3/29. Mr. Phillips reported after the bed cane was observed on Resident N's bed, staff were trained to remove them when found in the facility. Mr. Phillips reported this training will be outlined in the corrective action plan.

IV. RECOMMENDATION

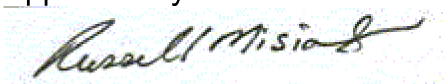
Upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

Lauren Wohlfert

2/22/19

Lauren Wohlfert — Date
Licensing Staff

Approved By:



3/27/19

Russell B. Misiak
Area Manager

Date