GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 25, 2019

Michael Dyki
Stonecrest Of Rochester Hills
1775 S. Rochester Road
Rochester Hills, MI 48307

RE: License #: AH630382887
Investigation #: 2020A1019012

Dear Mr. Dyki:

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. Failure to submit an acceptable corrective action plan will result in disciplinary action. 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 (248) 975-5053.

Sincerely,

Elizabeth Gregory-Weil, Licensing Staff
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(810) 347-5503

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

I. IDENTIFYING INFORMATION

License #:	AH630382887
Investigation #:	2020A1019012
Complaint Receipt Date:	10/23/2019
Investigation Initiation Date:	10/23/2019
Report Due Date:	12/22/2019
Licensee Name:	Stonecrest Senior Living, LLC
Licensee Address:	Suite 200 5015 NW Canal St. Riverside, MO 64150
Licensee Telephone #:	(816) 888-7380
Administrator and Authorized Representative:	Michael Dyki
Name of Facility:	Stonecrest Of Rochester Hills
Facility Address:	1775 S. Rochester Road Rochester Hills, MI 48307
Facility Telephone #:	(248) 266-7680
Original Issuance Date:	06/01/2018
License Status:	REGULAR
Effective Date:	12/01/2018
Expiration Date:	11/30/2019
Capacity:	105
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A eloped from the facility on 10/22/19.	Yes
Additional Findings	Yes

III. METHODOLOGY

10/23/2019	Special Investigation Intake 2020A1019012
10/23/2019	Comment- Facility staff submitted IR to LARA reporting the incident
10/23/2019	Special Investigation Initiated - Letter Emailed administrator requesting additional information
10/24/2019	APS Referral Notified APS of the elopement via emailed referral template
10/25/2019	Contact- Telephone Call Made Called administrator/AR Mike Dyki to obtain additional information
10/25/2019	Exit Conference

ALLEGATION:

Resident A eloped from the facility on 10/22/19.

INVESTIGATION:

On 10/23/19, facility staff submitted an incident report regarding an elopement that occurred on 10/22/19. The incident report read:

> At approximately 1530, the resident left the community unattended. He returned to the community at approximately 1640 with the Oakland County Sheriff's Department. Upon his return, the resident was assessed by the community nurse; vitals were within normal limits. A skin assessment was completed and revealed no bruises, tears or rashes. The resident was not in any distress and denied complaints of pain or discomfort.

Timeline of incident as follows:
1525 Care managers observed resident in dining room eating.1530 Dining room server saw resident leave community via bistro side door, server did not alert nursing staff.1545 Memory Care Director observed that resident was not in dining room went to memory care to determine if resident had returned to unit. 1550 Director of Health and Wellness was notified of possible elopement; elopement protocol was activated immediately. Director of Health and Wellness provided direction to team members, sweep of memory care was performed and a count of all residents performed. 1555 Executive Director notified. Three team members left community to search surrounding areas in vehicles; four team members searched community perimeter including parking lot. Another team member searched lower lever in Assisted Living and another team member searched the upper level in Assisted Living. All stairwells, restrooms and storage areas were checked. 1610 Resident's son (DPOA) and daughter were notified via phone.1620 Director of Health and Wellness was notified while on the phone with Oakland County Sheriff Department that the resident had been found safe and would be returning to the community by Oakland County Sheriff Department. Family notified by law enforcement of resident found and safe, prior to resident return to community. Resident was observed approximately one-half mile from community. Resident stated he was "looking for a restaurant."1640 Resident returned to the community. Resident assessed by community nurse. Head to toe assessment performed. 1700 Resident eating accompanied by his companion. Primary Care Physician (Dr. Rojas) and Psychiatrist (Dr. Emerson) notified; no new orders received at this time. PCP to evaluate resident 10/24/19; no new orders received at this time.

Health and wellness director Susannah Castillo stated that Resident A commonly eats in the assisted living dining room but that is not common practice for other memory care residents. Ms. Castillo stated that Resident A has previously expressed a desire to leave, but only in terms of leaving memory care and has not had a documented case of attempting to leave the actual community. Ms. Castillo stated that Resident A was receiving companion care services upon move into the community.

Review of Resident A's service plan that was in place at the time of the incident (dated 8/21/19) confirmed that he received companion services but did not specify how many days per week or hours per day the services were in place. Regarding exit seeking, Resident A's service plan read "[Resident A] will want to leave the community often to go live in Wisconsin with his son. When [Resident A] expresses his wish to leave the community team members should distract him with an activity or refreshment [Resident A] enjoys eating chocolate."

Ms. Castillo stated that the person who observed Resident A exit the facility is Josephine DiNardo. Ms. Castillo stated that Ms. DiNardo is a food service employee

through a third-party vendor (Morrison) and is not employed directly by the facility. A signed statement submitted by Ms. DiNardo read:

> When I was going to clean the dinning [sic] room to clean I saw [Resident A] walk out the bistro door and he started walking to the front of the building. About 30min later Susan and Katrina came in the dinning [sic] room asking where [Resident A] was, and I told them.

On 10/25/19, I spoke to administrator and authorized representative Michael Dyki by telephone. Mr. Dyki stated that Ms. DiNardo was aware that Resident A resided in memory care and she should have alerted other staff immediately when she saw Resident A leave the facility.

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.**
For Reference R 325.1901	**Definitions.**
	(16) "Protection" means the continual responsibility of the home to take reasonable action to ensure the health, safety, and well-being of a resident as indicated in the resident's service plan, including protection from physical harm, humiliation, intimidation, and social, moral, financial, and personal exploitation while on the premises, while under the supervision of the home or an agent or employee of the home, or when the resident's service plan states that the resident needs continuous supervision. **(22) "Supervision" means guidance of a resident in the activities of daily living, and includes all of the following:** **(d) Being aware of a resident's general whereabouts as indicated in the resident's service plan, even though the resident may travel independently about the community.**

ANALYSIS:	On 10/22/19, Resident A was allowed to leave the secured memory care facility where he resides to dine in the general assisted living area. Staff observed Resident A exit the facility unattended through a side door and did not follow proper procedure in alerting staff upon his exit and the employee also made no efforts to retrieve the resident. The resident was gone from the facility for over an hour before he was brought back to the facility by the police department. The resident was at great risk of harm while out of the facility unattended. Based on this information, the allegation is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Review of Resident A's service plan reveal that it lacked specific information regarding his dining preferences and did not stipulate the level of supervision he should have when out of the secured memory care area.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.
For Reference R 325.1901	**Definitions.**
	(21) "Service plan" means a written statement prepared by the home in cooperation with a resident and/or the resident's authorized representative or agency responsible for a resident's placement, if any, and that identifies the specific care and maintenance, services, and resident activities appropriate for each individual resident's physical, social, and behavioral needs and well-being and the methods of providing the care and services while taking into account the preferences and competency of the resident.

ANALYSIS:	Resident A's service plan wasn't adequately developed based on his preferences to eat in the non-secured, assisted living area of the facility and lacked essential instruction to staff regarding the level of supervision he required when outside of the memory care area. Based on this information, the facility did not comply with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Mr. Dyki stated that he was unable to produce any training documents to show that Ms. DiNardo had been trained at the facility on their elopement procedures prior to Resident A's elopement incident.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(6) The home shall establish and implement a staff training program based on the home's program statement, the residents service plans, and the needs of employees.
ANALYSIS:	The facility lacked a sufficient training program to demonstrate all people working in the facility receive adequate training to meet resident needs. Based on this information, the facility did not comply with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 10/25/19, I shared the findings of this report with authorized representative Michael Dyki.

IV. RECOMMENDATION

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

10/25/19

Elizabeth Gregory-Weil Date
Licensing Staff

Approved By:

10/25/19

Russell B. Misiak Date
Area Manager