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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 9, 2020

Michele Locricchio
Stonecrest Of Rochester Hills
1775 S. Rochester Road
Rochester Hills, MI 48307

RE: License #: AH630382887
Investigation #: 2020A1019041

Dear Ms. Locricchio:

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

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630382887
Investigation #:	2020A1019041
Complaint Receipt Date:	03/06/2020
Investigation Initiation Date:	03/06/2020
Report Due Date:	05/05/2020
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:	Michele Locricchio
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:	12/01/2019
Expiration Date:	11/30/2020
Capacity:	105
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident G eloped on 3/5/20.	Yes
Additional Findings	No

III. METHODOLOGY

03/06/2020	Special Investigation Intake 2020A1019041
03/06/2020	Comment LARA was notified via emailed incident report of the elopement
03/06/2020	Special Investigation Initiated - Letter Emailed AR/administrator to obtain additional information. Also requested a copy of resident's service plan.
03/06/2020	Contact - Document Received Resident service plan and additional information received via email from Jennifer Schuchard, Regional Director of Clinical Services
03/06/2020	Inspection Completed-BCAL Sub. Compliance
03/06/2020	APS referral
03/09/2020	Exit Conference

ALLEGATION:

Resident G eloped on 3/5/20.

INVESTIGATION:

On 3/5/20, facility staff submitted an incident report regarding an elopement that occurred earlier that morning. The incident report read:

> On March 5, 2020, at approximately 01:50am, [Resident G] was observed outside employee entrance by team member Milan Nellard. Team member was leaving community to start his vehicle when he observed the resident near the employee entrance. The resident was observed fully dressed, wearing gray sweats, a coat, hat, gloves and boots. She was brought into the community by team member Milan Nellard who brought resident to memory care and notified Diamond Rice. Diamond Rice notified nurse Uronda Bolton at approximately 02:01am. The resident was last observed by team member Diamond Rice and Milan Nellard at 01:15am, when they were performing rounds. Diamond and Milan observed the resident in blue snowflake pajamas and asleep at that time. Diamond and Milan left resident room and continued rounds. Milan left the Memory Care unit to start his vehicle at approximately 01:45am, where he observed the resident when he left the community using the employee entrance.

A statement was obtained from medication manager Diamond Rice that read:

> I, Diamond Rice last seen [Resident G] at 1:15am. [Resident G] was in bed with her blue snowflake pj's on. We finished rounds at 1:30am and Milan left around 1:45am. Milan told me he found a resident outside. I observed [Resident G] fully dressed in coat, hat, gloves, gray sweat pants and winter boots being escort by Milan into Memory Care. I then pressed to call the nurse on shift at 2:01am.

A statement was obtained from care staff Milan Nellard that read:

> I, Milan Nellard, was rounding with Diamond Rice. We last saw [Resident G] at 01:15am when we rounded in her apartment. She was dressed in blue pajamas with snowflakes on them and was asleep at that time. We continued round and left memory care at about 01:45am. I left the community using the employee entrance about 01:50am. When I exited the community, I saw [Resident G] near the employee entrance. She was wearing gray sweats, a coat, hat, gloves and boots. I brought her back to memory care and to Diamond at that time. Diamond notified the nurse at approximately 02:01am.

A statement was obtained from nurse Uronda Bolton that read:

> Writer Uronda Bolton was notified by caregiver Diamond Rice that [Resident G] was retuned back to the facility by Milan- caregiver. Writer observed resident with clothes fully dressed with coat and hat and glasses on. Writer asked was she ok and any pain and where was she going and how did she get out. Resident stated that she didn't know, and that she was going to her car to get her husband…

On 3/5/20, email correspondence began between licensing staff and regional director of clinical services Jennifer Schuchard. Ms. Schuchard reported the following:

We believe that a team member disarmed the Detex unit on the Memory Care Fire Door. We have recored [sic] the Detex unit to disable all previous keys. Now the only key will be with the Executive Director and/or Designee and the Director of Plant Operations. We do not have security cameras. We know that she was last observed asleep at 01:15am during rounds and that she was observed outside near the employee entrance at approximately 01:50am. Prior to her move to memory care she did not have a history of exit seeking. She was mobile throughout the community but was not observed to exit seek. She moved to memory care on March 1, 2020 due to an increase in confusion, sleeping during the day and spending more time in her room. She would wander inside the community but did not exit the community until March 4, 2020. On March 4, 2020 at approximately 10:45 she was watched exiting the community by a team member who followed her and brought her back in immediately. The resident was easily redirected into the community.

Upon request, Ms. Schuchard provided a copy of the incident report for the 3/4/20 elopement incident. That report read:

The care managers in memory care (Alishia, Rain, Endia, Kee) observed resident at breakfast. They noted that she returned to her room after breakfast. The caregivers were in the dining room clearing tables when Nicole, Assisted Living Medication Manager, and Daeuanna, server from the kitchen, entered the memory care unit with he resident. Daeuanna stated she visualized the resident as she opened the exit door Daeuanna got out of her vehicle and escorted the resident into the community using the employee entrance. The nurse, Priscilla, assessed the resident head to tor and did not observe any discoloration or signs of injury. Family and PCP were notified.

Ms. Schuchard reported that she believed the 3/4/20 happened as a result of a disengaged door alarm as well.

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:	Resident G moved in the facility's memory care unit on 3/1/20. On 3/4/20, Resident G was seen exiting the facility by a staff member outside in their vehicle and was immediately bought back in. On 3/5/20, Resident G was found outside at approximately 1:50am, and was last seen prior to the incident by staff at 1:15am. The resident was at risk of harm while out of the facility unattended. The facility has lacked a reasonable organized program and not demonstrated compliance with this rule. Based on this information, the allegation is substantiated.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED [For reference. See special investigation report # SIR2020A1019012].**

On 3/9/20, I shared the findings of this report with authorized representative Michele Locricchio.

IV. RECOMMENDATION

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

3/6/20

Elizabeth Gregory-Weil Date
Licensing Staff

Approved By:

3/6/20

Russell B. Misiak Date
Area Manager