STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

June 3, 2021

Joseph Bacall
Michigan House Senior Living
18533 Quarry Road
Riverview, MI 48193

RE: License #: AH820389597
Investigation #: 2021A1011031
Michigan House Senior Living

Dear Mr. Bacall:

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 licensee authorized representative 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 (248) 975-5053.

Sincerely,

Andrea Krausmann, Licensing Staff
Bureau of Community and Health Systems
51111 Woodward Avenue 4th Floor, Suite 4B
Pontiac, MI 48342
(586) 256-1632

enclosure

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

## I. IDENTIFYING INFORMATION

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|---|---|
| **License #:** | AH820389597 |
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| **Investigation #:** | 2021A1011031 |
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| **Complaint Receipt Date:** | 05/12/2021 |
| | |
| **Investigation Initiation Date:** | 05/12/2021 |
| | |
| **Report Due Date:** | 07/11/2021 |
| | |
| **Licensee Name:** | Michigan House Senior Living LLC |
| | |
| **Licensee Address:** | 12525 Hale Street<br>Riverview, MI 48193 |
| | |
| **Licensee Telephone #:** | (248) 538-0585 |
| | |
| **Administrator:** | Gabriela Birkner |
| | |
| **Authorized Representative:** | Joseph Bacall |
| | |
| **Name of Facility:** | Michigan House Senior Living |
| | |
| **Facility Address:** | 18533 Quarry Road<br>Riverview, MI 48193 |
| | |
| **Facility Telephone #:** | (734) 283-6000 |
| | |
| **Original Issuance Date:** | 10/25/2019 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 04/25/2021 |
| | |
| **Expiration Date:** | 04/24/2022 |
| | |
| **Capacity:** | 42 |
| | |
| **Program Type:** | ALZHEIMERS<br>AGED |

## II. ALLEGATION(S)

| | **Violation Established?** |
|---|---|
| Resident A wandered away from the facility unnoticed by staff. | Yes |
| Additional Findings | Yes |

## III. METHODOLOGY

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|---|---|
| 05/12/2021 | Special Investigation Intake<br>2021A1011031 |
| 05/12/2021 | Special Investigation Initiated - Letter<br>Email to administrator Gabriela Birkner requesting documentation. |
| 05/12/2021 | APS Referral<br>Referral sent to adult protective services via email. |
| 05/12/2021 | Contact - Document Received<br>APS Centralized Intake Worker Tasha Smith confirmed receipt. |
| 05/12/2021 | Contact - Document Received<br>Documentation received via email from G. Birkner. |
| 06/02/2021 | Contact - Telephone call made<br>Interviewed admin G. Birkner and Assistant Resident Care Director Lindsey Doolin. |
| 06/02/2021 | Contact - Document Received<br>Face sheet from G. Birkner via email upon request. |
| 06/02/2021 | Contact - Telephone call made<br>Called Wyandotte Police Dept. records dept. Alice Baker. |
| 06/02/2021 | Contact - Document Sent<br>Requested police report abaker@wyandottemi.gov |
| 06/02/2021 | Contact - Document Received<br>Wyandotte Police report received. |
| 06/02/2021 | Contact - Telephone call made<br>Interviewed Destiny Hensley. |

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| 06/03/2021 | Contact - Telephone call made<br>Follow-up with G. Birkner and L. Doolin |
| 06/03/2021 | Exit Conference – Conducted with licensee authorized representative Joseph Bacall via telephone. |

**ALLEGATION:**

**Resident A wandered away from the facility unnoticed by staff.**

**INVESTIGATION:**

On 5/11/21, the facility submitted an incident report to the department. On 5/12/21, I requested additional documentation from the facility's administrator Gabriela Birkner and I made a referral to adult protective services.

Due to the Covid pandemic, this investigation was conducted remotely.

The incident report read that on 5/10/21 at 11:56 pm staff Bonnie Bowholtz texted assistant resident care director Lindsay Doolin to notify her that the police just pulled up to the facility. Resident A and her family were also there waiting to be allowed into the facility by staff person Destiny Hensley. Resident A's family notified Ms. Hensley that Resident A had left the facility, was picked up by the police, and brought to their home in Trenton, MI.

Resident A had just moved into Michigan House Senior Living earlier that day at 1:30 pm, because she has dementia and she had been wandering away from her family home. Ms. Doolin completed a skin assessment and documented "everything was within normal range and no apparent injuries to [Resident A]". Resident A reportedly stated she was fine.

Ms. Doolin conducted an investigation by contacting evening shift staff. Ms. Bowholtz reportedly told Ms. Doolin that there was a lady that she let out of the building that she thought was a visitor based upon her appearance. Ms. Doolin confirmed with Ms. Bowholtz by verbal description that it was Resident A.

The incident report also included statements reportedly made by Ms. Bowholtz and by Ms. Hensley to Ms. Doolin on 5/11/21. The statement by Ms. Bowholtz was written as, "When I arrived for my shift around 7pm I entered the facility. I was doing my COVID 19 screening. A lady approached me and asked me if I could let her out. She was well dressed; hair and make-up done and had a bag draped on her shoulder. I asked her if she had a nice visit. I have never seen this lady before, but I am a new employee (this is my second week on the job). We had a conversation about her visit and how nice the facility was. As I let her out of the facility, we continued to chat and then I ran back to my car to get my training packet. At the end

of my shift, I was getting into my car and two police officers pulled up to the facility. I messaged Lindsay and let her know that two police officers were coming to the door and I left."

The statement by Ms. Hensley indicated she answered the doorbell for the police, Resident A, and her family. The family stated Resident A had gotten out of the facility.

On 5/12/21, I received the facility's assessment of Resident A and two service plans; one completed upon admission and one after the elopement. The assessment revealed Resident A was diagnosed with Alzheimer's disease, COPD, hyper lipidemia, hypertension, heart disease, sleep apnea and GERD. She was independent with most personal care needs, but she did require stand by assistance with bathing, medication management, activity reminders, and laundry services. The service plan also has checked boxes documenting that Resident A has attempted to leave or has successfully left the environment, she must be accompanied by an escort and she chooses or needs staff to help her with making calls or make the calls on her behalf.

The 5/10/21 service plan revealed Resident A was 71 years old, and it includes, "Oriented to person, not time or place…ambulates independently…No assistive devices… Behavioral: High risk for elopement. Verbally states that she wants to leave the facility… must be supervised anytime she leaves the facility…can go out to the secured courtyard with the staff (due to her high risk for elopement)…".

On 6/2 and 6/3/21, I interviewed administrator Gabriela Birkner and Lindsay Doolin by conference calls. They affirmed that Resident A had been admitted on 5/10/21 at 1:30 pm and placed in the assisted living area of the facility. Although Resident A was diagnosed with dementia, Ms. Birkner and Ms. Doolin explained that the family did not want her residing in the memory care unit because she communicates at a level on par with residents in the assisted living area. Ms. Birkner explained that all facility exit doors are locked. It is necessary for staff to enter a code to unlock the door and allow persons out, even from the assisted living area. Ms. Doolin had come into the building about 11 pm that evening and was on-site when Resident A was returned. Resident A's physician was notified at 12:15 am. Relative A1 was Resident A's authorized representative and was notified by the police when Resident A was brought to his home.

On 6/2/21, I received and reviewed the Wyandotte Police report 2021-00001732. It indicates that on 5/10/21 at 2241 hours (10:41 pm) police were dispatched to the area of 12$^{th}$ and Cedar streets in Wyandotte for a welfare check of an elderly female later identified as Resident A. The reporting party informed police that he was walking his dog around Pulaski Park when he observed Resident A pacing back and forth near the park. He found Resident A's behavior to be suspicious and attempted to make contact with her. He followed her until she sat on the ground at the southwest corner of 12$^{th}$ at Cedar Street and then called the police.

The police officer then wrote about his interaction with Resident A, "While speaking with [Resident A], she appeared to be cold and disoriented. [Resident A] was wearing a thin windbreaker style jacket and blue jeans and the outdoor temperature was approximately 50 degrees. WYFD [Wyandotte Fire Dept.] was summoned to the scene to assess [Resident A's] vitals. WYFD advised that [Resident A's] vitals were stable and cleared the scene. I asked [Resident A] what year it was (sic) and she stated 1967. I asked [Resident A] if she knew where she was and she stated not far from Trenton. [Resident A] stated she left her residence at approximately 1630 hours [4:30 pm] to buy her husband, [Relative A1], a gift for his birthday. [Resident A] could not recall her address or who the current president was."

The police report continues that a LEIN/SOS query of [Resident A] revealed an address in Trenton as her registered address. The query also revealed that Trenton police department had a missing person report on file for Resident A from 4/10/21 (Report #2021-00003615). Resident A was transported to Beaumont Hospital in Trenton on that date.

On 5/10/21, police officers transported Resident A to the Trenton address they had on file and made contact with Relative A1 at the location. Relative A1 advised that Resident A does not live at this location and is currently living at Michigan House Senior Living. Relative A1 informed the police that Resident A was diagnosed with dementia approximately one year ago. Trenton police dept. then contacted Relative A2 and she arrived at the location of Relative A1. Relative A1 and Relative A2 drove to Michigan House Senior Living and the Wyandotte police officers transported Resident A. Upon arrival, facility staff informed Relative A1 that they did not know Resident A was missing. Resident A was turned over to staff. The incident was captured on the police officer's body worn camera.

Review of google maps revealed distance from Michigan House Senior Living 18533 Quarry Road Riverview to Pulaski park and the corner of 12th and Cedar in Wyandotte, is approximately 3.2 miles away.

| **APPLICABLE RULE** | |
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| **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: R325.1901** | **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** |

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| | **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:** | Upon admission, Resident A's 5/10/21 service plan identified her as being at high risk for elopement, including that she verbally stated she wanted to leave the facility. The service plan contained no specific care services and methods to address her need for protection and safety from elopement, other than that she could go out to the courtyard with staff. Consequently, Resident A's needs for protection and safety were not assured, as she exited the facility unsupervised, and her absence was not noticed by staff for five hours. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**ADDITIONAL FINDINGS:**

**INVESTIGATION:**

I confirmed with Ms. Birkner and Ms. Doolin that Resident A had left the building at approximately 7 pm. Ms. Doolin returned to the facility approximately 11 pm. No staff had noticed that Resident A was away from the building until she was returned by her family and police at 11:56 pm, five hours later. Ms. Birkner said the facility did not have a safety check policy in place at that time. Staff were only verbally told to check on residents throughout the night. Given Resident A's independence in personal care, Ms. Birkner said it was expected that staff would have checked on her at bedtime around 10 pm, but they did not.

| **APPLICABLE RULE** | |
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| **R 325.1921** | **Governing bodies, administrators, and supervisors.** |
| | **(1) The owner, operator, and governing body of a home shall do all of the following:**<br><br>**(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: R325.1901** | **Definitions.** |

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| | **(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.**<br><br>**(23) "Supervision" means guidance of a resident in the activities of daily living, and includes all of the following:**<br><br>**(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:** | The facility had no organized program in place of protection and supervision to be aware of the resident's general whereabouts, as evidenced by Resident A being a brand-new resident home at high risk for elopement and no one checked on her for five hours. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**INVESTIGATION:**

Corrective measures to prevent recurrence written on the incident report read, "All residents will be required to wear and (sic) identification wristband. A wander binder will be created and left at the receptionist des. The wander binder will include resident name, room number and photo. All visitors will be required to wear visitor badges. Inservice for all staff within one week to review elopement policy and procedures".

Resident A's service plan includes 5/11/21 updates of "Due to [Resident A] eloping the night she arrived, Resident's photo has been placed in our wonder (sic) book at the front desk. [Resident A] was asked to always wear an identification band. . . Staff are required to do safety checks throughout the night." The service plan was signed by Ms. Doolin and dated 5/11/21, but there is no indication that Resident A and her authorized representative were notified of the changes to the plan.

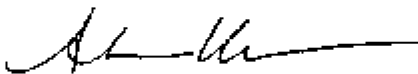
Neither the corrective measures nor Resident A's service plan addressed new staff being unfamiliar with new residents and allowing persons out of the building.

| APPLICABLE RULE | |
|---|---|
| **R 325.1922** | **Admission and retention of residents.** |
| | **(5) A home shall update each resident's service plan at least annually or if there is a significant change in the resident's care needs. Changes shall be communicated to the resident and his or her authorized representative, if any.** |
| **ANALYSIS:** | There is no evidence that Resident A and her authorized representative were informed of the 5/11/21 changes to her service plan.<br><br>It is also noted that the service plan update of conducting safety checks throughout the night but provides no specific methods of how and when these safety checks are to be implemented by staff. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

On 6/3/21, I reviewed the findings of this report with licensee authorized representative Joseph Bacall via telephone.

## IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, it is recommended that the status of the license remain unchanged.



6/3/21

Andrea Krausmann Date
Licensing Staff

Approved By:

6/3/21

Russell B. Misiak Date
Area Manager