



STATE OF MICHIGAN
 DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
 LANSING

GRETCHEN WHITMER
 GOVERNOR

ORLENE HAWKS
 DIRECTOR

February 23, 2022

Sara Dickendesher
 Senior Living Crestwood, LLC
 7927 Nemco Way, Ste 200
 Brighton, MI 48116

RE: License #:	AH370406206
Investigation #:	2022A1021025
Crestwood Village Assisted Living & Memory Care	

Dear Ms. Dickendesher:

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.

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 (517) 284-9730.

Sincerely,

Kimberly Horst, Licensing Staff
 Bureau of Community and Health Systems
 611 W. Ottawa Street
 Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH370406206
Investigation #:	2022A1021025
Complaint Receipt Date:	01/31/2022
Investigation Initiation Date:	01/31/2022
Report Due Date:	03/02/2022
Licensee Name:	Senior Living Crestwood, LLC
Licensee Address:	7927 Nemco Way, Ste 200 Brighton, MI 48116
Licensee Telephone #:	(989) 772-2183
Administrator:	Myndy Sanders
Authorized Representative:	Sara Dickendesher
Name of Facility:	Crestwood Village Assisted Living & Memory Care
Facility Address:	2378 S. Lincoln Road Mt. Pleasant, MI 48858
Facility Telephone #:	(989) 772-2183
Original Issuance Date:	06/02/2021
License Status:	REGULAR
Effective Date:	12/02/2021
Expiration Date:	12/01/2022
Capacity:	57
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A eloped from the facility.	Yes
Additional Findings	No

III. METHODOLOGY

01/31/2022	Special Investigation Intake 2022A1021025
01/31/2022	APS Referral intake received from APS
01/31/2022	Special Investigation Initiated - Letter requested Resident service plan
02/01/2022	Contact - Telephone call made interviewed administrator
02/01/2022	Contact-Telephone call made Interviewed caregiver Sidney Page
02/23/2022	Exit Conference Exit Conference with authorized representative Sara Dickendesher

ALLEGATION:

Resident A eloped from the facility.

INVESTIGATION:

On 1/31/22, the licensing department received a complaint from Adult Protective Services (APS) with allegations Resident A was found outside the facility. The complainant alleged it was unknown how long Resident A was outside the facility.

On 2/1/22, I interviewed administrator Myndy Sanders by telephone. Ms. Sanders reported the front door is typically secured with a code but on this day, a residents family member was moving a resident out of the facility. Ms. Sanders reported the family member propped open the front door with a bucket of salt. Ms. Sanders reported Resident A exited the facility when the door was left opened. Ms. Sanders

reported Resident A crossed the road and was found in a parking lot across the street. Ms. Sanders reported a passerby observed Resident A and contacted the facility to inquire if Resident A resided at the facility. Ms. Sanders reported Resident A was then brought back to the facility. Ms. Sanders reported Resident A did not have any injuries and was outside for approximately 10-15 minutes. Ms. Sanders reported the facility has conducted an internal investigation. Ms. Sanders reported the facility is working with the door alarm company to ensure the door was working properly. Ms. Sanders reported the facility is working to install another alarm system to ensure this type of event does not happen again. Ms. Sanders reported caregivers report they do not recall providing the door alarm to the residents' family. Ms. Sanders reported re-education has been provided to all staff on proper protocol with providing the door alarm. Ms. Sanders reported the following day Resident A moved to the secure memory care unit and is adjusting well to the move. Ms. Sanders reported Resident A has resided in the facility for approximately two weeks. Ms. Sanders reported prior to this incident, the facility had been working with Resident A's family on moving Resident A to the secure memory care unit, but family was hesitant to move Resident A to a more restrictive environment. Ms. Sanders reported Resident A would spend daytime hours in the memory care unit for a more secure environment. Ms. Sanders reported Resident A has never attempted to leave the facility prior to this incident.

On 2/1/22, I interviewed caregiver Sidney Page by telephone. Ms. Page reported she was the care coordinator when Resident A eloped. Ms. Page reported she was in the secure memory care unit assisting another resident's family with moving the resident out of the building. Ms. Page reported she assisted the resident's family with the secure front entrance door. Ms. Page reported she is unsure who propped open the door. Ms. Page reported she had a visual on Resident A approximately 20 minutes before the incident occurred. Ms. Page reported she came back to the assisted living unit and a woman was in the entryway and reported there was an elderly man in pajamas outside the facility. Ms. Page reported Resident A was brought back to the facility and ate dinner. Ms. Page reported the woman reported Resident A fell but the facility did not observe any injuries to Resident A. Ms. Page reported Resident A was at baseline and all appropriate parties were notified. Ms. Page reported the facility increased checks on Resident A and the following day Resident A was moved to the secure memory care unit. Ms. Page reported Resident A is confused but is easily re-directable. Ms. Page reported Resident A had no history of trying to open the doors and leave the facility but would often wander around the facility. Ms. Page reported she provided education to all staff members on door policy and ensuring the door is not propped open.

I reviewed the incident report submitted to the licensing department. The narrative of the incident report read,

“Resident with dx dementia, exited building from the main entrance door. Door was found to be propped open by another residents family attempting to move furniture. Due to this no door alarm activated. Resident crossed Lincoln Rd and

went to the parking lot of the church across the road. Witness called facility and brought resident back to the facility. Resident was out of the building for approximately 15 to 20 min. Witness reported to staff police were called and that she had observed resident fall in the parking lot. Upon return resident showed no signs of a fall, no injury, and when asked stated he did not fall.”

The corrective actions of the incident report read,

“Staff training will be conducted on Elopement and door procedure/safety. Resident was moved to Memory Care and will have follow up with PCP.”

I reviewed observation notes for Resident A. The notes read,

“1/18: Staff observed resident to be having adjustment issues. He’s attempted to walk out the main entrance several times. Staff has re directed him. Since then, he has calmed down.

1/18: resident was having some confusion this evening at dinner time, although he did eat a good portion of his dinner he seemed to be exit seeking and confused as to why he was at the facility, staff redirected him several times and tried comforting him by letting him know that we would be staying here with him for a couple days. Resident eventually was able to calm down and lay in bed, at 8pm med pass, staff attempted to enter residents room and noticed that the door was blocked from the inside with a suit case and tv dinner trays, however the resident was laying in bed, staff is unsure if this was done by the resident on purpose, he took his medication with no issues and appeared to be very grateful for the staffs help of turning off his tv. Resident is currently resting in bed.

1/19: Resident appeared to be up and awake during room checks, resident was still confused and wondered when he was going home, staff let him know that it was very early in the morning that he was going to be staying the rest of the night, resident understood and went back to bed, no issues.

1/20: Resident was having confusion this evening trying to go outside and said someone was waiting for him in his car. He notified staff that he would really like a shower so staff assisted him with a shower around 7pm.

1/21: Resident appeared in good spirits today. He had both meals in (assisted living) dining area. He was a little confused throughout the shift. When staff came to get him for breakfast, resident asked what belonged to him in his room. He also mentioned where he would pay for his stay, stating he had to leave for shepard. Staff assured him that this was his home, and that he didn’t have to pay. Resident was pretty insistent on leaving but was eventually redirected towards eating breakfast.

1/21: Resident appeared in good spirits but confused. He would come out of his room with some of his items stating that he’s leaving and was wondering where his car was. Staff told resident that his car is out for repairs and won’t be brought back till tomorrow. Resident seemed satisfied with this answer and seemed to stop exit seeking.

1/22: Resident appeared very confused today and was asking staff over and over again to call the dealerships in town to see if they had a car he could borrow, staff told him that the dealerships were closed on Saturdays and we would have to wait until Monday, resident went to (memory care) for dinner and is now sleeping in bed.

1/23: Resident came out to the dining room multiple times today and wanted to leave and go home. Staff talked to resident and showed him to his room and explained that this was his new home.

1/26: Resident appeared to be very confused looking for their car. Staff redirected resident saying it was in the shop and that seemed to help the resident forget about it. Resident ate dinner in the dining room before heading back to their room for the evening.

1/27: Resident ate dinner in dining area. He appeared to be a bit confused today saying he needed to find his car and told staff he doesn't understand why he is here. Staff redirected resident saying this is his apartment and that he lives here. He calmed down and is currently in his apartment.

1/28: Today around 5pm resident was returned to the facility by a female bystander, she stated resident had walked across the road to the church, trying to find a ride back home and suspected the resident has fallen. Resident eloped from building due to the main entrance door being propped open while another residents family was moving furniture. Staff assessed the residents body and see no signs of a fall or injury. Resident came back into the facility and ate all of his dinner, staff was able to get him into the shower and into bed. CC did an education with staff members about the importance of keeping all doors closed and closely monitoring residents. CC contacted ED and from there ED and DRF made the appropriate calls, staff also filled out IR and faxed PCP. Resident is currently sleeping in bed, resident will be moved to memory care on 1/29/22."

I reviewed Resident A's service plan. The service plan read,

"Requires regular prompting due to confusion and disorientation. Has limited safety awareness and needs to be supervised outside on campus grounds. May stay in secure area unsupervised. Must have supervision for off campus trips. Requires baseline monitoring at change of each shift, mid-day meal and once per mid third shift."

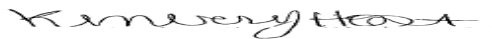
APPLICABLE RULE	
R 325.1921	Governing bodies, administrators, and supervisors.
	<p>(1) The owner, operator, and governing body of a home shall do all of the following:</p> <p>(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.</p>

For Reference: R 325.1901	Definitions.
	(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 A was known to be confused and voice the desire to leave the community. Resident A exhibited these behaviors between 1/18-1/28. Resident A's plan was not updated during this ten-day period to reflect his increasing need for supervision. Specifically, it lacked the frequency of safety checks and level of one-to-one supervision he required due to his consistently demonstrated behaviors and his cognitive deficits. Due to this insufficiently developed plan, staff were not aware of his whereabouts allowing him to elope unnoticed and at risk of harm by leaving the facility unsupervised. The facility lacked an organized program of supervision and reasonable protective measures to keep him safe.
CONCLUSION:	VIOLATION ESTABLISHED

On 2/23/22, I conducted an exit conference with authorized representative Sara Dickendeshier by telephone. Ms. Dickendeshier had no questions regarding the findings in this report.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the status of the license.



2/11/22

Kimberly Horst
Licensing Staff

Date

Approved By:



02/22/2022

Andrea L. Moore, Manager
Long-Term-Care State Licensing Section

Date

