GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 3, 2022

Megan Rheingans
Commerce Comfort Care LLC
4180 Tittabawassee Rd.
Saginaw, MI 48604

RE: License #:	AH630394418
Investigation #:	2022A1021045
	Commerce Comfort Care

Dear Ms. Rheingans:

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 #:	AH630394418
Investigation #:	2022A1021045
Complaint Receipt Date:	04/20/2022
Investigation Initiation Date:	04/20/2022
Report Due Date:	06/20/2022
Licensee Name:	Commerce Comfort Care LLC
Licensee Address:	4180 Tittabawassee Rd. Saginaw, MI 48604
Licensee Telephone #:	(989) 607-0001
Administrator:	Tamara Levites
Authorized Representative:	Megan Rheingans
Name of Facility:	Commerce Comfort Care
Facility Address:	100 Decker Rd. Walled Lake, MI 48390
Facility Telephone #:	(989) 607-0001
Original Issuance Date:	01/15/2021
License Status:	REGULAR
Effective Date:	07/15/2021
Expiration Date:	07/14/2022
Capacity:	73
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

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

III. METHODOLOGY

04/20/2022	Special Investigation Intake 2022A1021045
04/20/2022	Special Investigation Initiated - Letter referral sent to centralized intake at APS
04/21/2022	Contact - Telephone call made interviewed administrator
04/21/2022	Contact - Telephone call made interviewed SP1
04/21/2022	Contact - Telephone call made interviewed SP2
04/21/2022	Contact - Telephone call made interviewed SP3
04/22/2022	Contact - Document Received chart documents received
05/03/2022	Exit Conference Exit Conference with authorized representative Megan Rheingans

ALLEGATION:

Resident B eloped from the facility.

INVESTIGATION:

On 4/20/22, the licensing department received a complaint with allegations Resident B eloped from the facility. The complainant alleged on 4/9/22, Resident B left the dinning room and walked outside the facility. The complainant alleged Resident B walked ¾ a mile and sustained injuries.

On 4/20/22, the allegations in this report were sent to centralized intake at Adult Protective Services (APS).

On 4/21/22, I interviewed the administrator Tamara Levites by telephone. Ms. Levites reported Resident B eloped from the building a few months ago but unsure on date as she was not the administrator at that time. Ms. Levites reported on 4/9/22, Resident B attempted to exit seek but pushing on the door. Ms. Levites reported around dinner time, Resident B walked out the side exit door and down the street. Ms. Levites reported staff members heard the alarm and immediately started the elopement protocol. Ms. Levites reported staff members could not locate Resident B and started to look outside. Ms. Levites reported staff members were able to locate Resident B outside after approximately 15-20 minutes. Ms. Levites reported Resident B is now on hourly checks. Ms. Levites reported Resident B will be moving to the secure memory care unit once it is opened which should be in Mary 2022.

On 4/21/22, I interviewed staff person 1 (SP1) by telephone. SP1 reported on 4/9/22, Resident B had attempted to exit the building by holding on the door and sounding the alarm. SP1 reported she was able to re-direct Resident B before she was able to leave the building. SP1 reported later in the day, she brought Resident B down to the dinning room to eat dinner. SP1 reported she then went to another resident's room and then another caregiver called for assistance because Resident B eloped from the building. SP1 reported all employees started the elopement process to search for Resident B. SP1 reported a pharmacist and head chef located Resident B outside after approximately 10-15 minutes. SP1 reported Resident B is now on hourly checks. SP1 reported Resident B tends to exit seek and try to leave the building.

On 4/21/22, I interviewed SP2 by telephone. SP2 reported on 4/9/22 she was assisting with the dinner service and observed Resident B to walk away from the table. SP2 reported she then heard the door alarm and the facility started the elopement process. SP2 reported Resident B was able to be located within 10-15 minutes. SP2 reported Resident B always tries to leave the facility and is constantly exit seeking. SP2 reported Resident B is now on hourly checks.

On 4/21/22, I interviewed SP3 by telephone. SP3 statements were consistent with those made by SP1 and SP2.

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

> *"3/21/22: Resident has been a bit more emotional lately. Talks of going home a lot. Redirection is giving more frequently lately. Daughter has been LOA from facility due to surgery. This may be affecting her mood. Spoke with other daughter a few days ago and let her know about mood changes. Will monitor. 4/11/22: Resident escaped the building on Saturday at 5:22pm. Staff responded and followed protocol. Resident was found down the street. 911 was notified and responded. She was taken to the hospital. Resident had fallen and hit her head*

on the pavement. Res returned from hospital that evening and presented with bruises around her left eye, bruise and bump on left side forehead. Cut on lip and bruise on chin. Res denies pain. Tylenol will be given today for pain due to face grimacing."

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

"Wandering: Problem interferes with daily functioning.
Elopement Risk: Monitor whereabouts at all times.
Safety: Staff will check on the resident's whereabout and safety regularly throughout the day, around the clock"

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.**
	(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 B was known to be exit seeking and voiced wanting to leave the community. Resident B's service plan did not reflect her increasing need for supervision. Specifically, it lacked the frequency of safety checks and level of one-to-one supervision she required due to her consistently demonstrated behaviors. Due to this insufficiently developed plan, she was able to elope and was at risk of harm by leaving the facility unsupervised. The facility lacked an organized program of supervision and reasonable protective measures to keep her safe.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 5/3/22, I conducted an exit conference with authorized representative Megan Rheingans by telephone. Ms. Rheingans 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.

4/22/22

Kimberly Horst — Date
Licensing Staff

Approved By:

05/02/2022

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