GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 18, 2022

Melissa Doss
CMHB Of CEI Counties
Suite 115
812 E Jolly Road
Lansing, MI 48910

RE: License #: AM230249421
Investigation #: 2022A0790004
MLK Road Home

Dear Ms. Doss:

Attached is the Special Investigation Report for the above referenced facility. Due to the quality of care violations identified in the report, a six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan and it 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 responsible party 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.

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,

Rodney Gill, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM230249421
Investigation #:	2022A0790004
Complaint Receipt Date:	03/09/2022
Investigation Initiation Date:	03/10/2022
Report Due Date:	05/08/2022
Licensee Name:	CMHB Of CEI Counties
Licensee Address:	Suite 115 812 E Jolly Road Lansing, MI 48910
Licensee Telephone #:	(517) 346-8200
Administrator:	Melissa Lynn Doss
Licensee Designee:	Melissa Lynn Doss
Name of Facility:	MLK Road Home
Facility Address:	300 North Michigan Eaton Rapids, MI 48827
Facility Telephone #:	(517) 663-2374
Original Issuance Date:	04/09/2003
License **Status:**	REGULAR
Effective Date:	12/22/2020
Expiration Date:	12/21/2022
Capacity:	12
Program Type:	MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A eloped from MLK Road Home on 03-04-2022 and was struck by a vehicle on North Michigan Road. She passed away from the injuries she sustained. Concern that Resident A was not provided with adequate supervision from direct care staff members.	Yes
Additional findings:	Yes

III. METHODOLOGY

03/09/2022	Special Investigation Intake 2022A0790004
03/10/2022	Incident Report received.
03/10/2022	Special Investigation Initiated - Face to Face
03/10/2022	Inspection Completed On-site
03/14/2022	Contact - Telephone call made- Interviewed direct care staff member Mary Merz.
03/14/2022	Contact - Telephone call made- Interviewed direct care staff member Shannon Campbell.
03/14/2022	Contact - Telephone call made- Interviewed direct care staff member Kerry Thelen.
03/14/2022	Contact - Telephone call made- Interviewed direct care staff member Shamondra Harris.
03/25/2022	Contact - Document Sent- Police report request emailed to MSP.
03/30/2022	Contact - Telephone call made- Interviewed Resident A's nephew/guardian via phone.
04/14/2022	Contact - Document Received- Michigan Department of State Police Original Incident Report
04/20/2022	Inspection Completed-BCAL Sub. Compliance
04/20/2022	Corrective Action Plan Requested and Due on 05/05/2022

05/04/2022	Telephone call to Melissa Doss- left multiple messages with no return call.
05/05/2022	Telephone call to Melissa Doss- left multiple messages with no return call.
05/05/2022	Contact – Telephone call made to direct care staff member Mary Merz to gain additional information regarding this investigation.
05/09/2022	Special Investigation Pending
05/04/2022	Contact - Telephone call made to licensee designee Melissa Doss to conduct an exit conference. Voicemail message left requesting a return call.
05/04/2022	Contact - Telephone call made to licensee designee Melissa Doss to conduct an exit conference. Voicemail message left requesting a return call.
05/05/2022	Contact – Telephone call made to licensee designee Melissa Doss to conduct an exit conference. Voicemail message left requesting a return call.
05/06/2022	Contact – Document Sent - emailed licensee designee Melissa Doss requesting a response to conduct an exit conference for this Special Investigation.
05/09/2022	Contact – Telephone call received from licensee designee Melissa Doss returning voicemail and email messages.
05/11/2022	Contact – Telephone call received from licensee designee Melissa Doss. Ms. Doss left a voicemail message requesting a return call to discuss this Special Investigation and conduct an exit conference.
05/13/2022	Contact – Telephone call made to Michigan State Police Lansing Post attempting to gather additional information regarding previous automobile/pedestrian accidents involving residents living at MLK Road Home. Left voicemail message requesting a call from Trooper Harris Edwards the 3rd.
05/13/2022	Contact - Telephone call made to the Michigan State Police Post located in Dimondale, MI to gather additional information regarding automobile/pedestrian accidents involving residents living at MLK

	Road Home. I was told that I would need to request that information through a FOIA request.
05/13/2022	Document Sent: FOIA request made with the Michigan State Police - Lansing Post requesting information and police reports involving automobile-pedestrian accidents involving residents living at MLK Road Home in Eaton Rapids, MI.
05/13/2022	Exit Conference held with licensee designee Melissa Doss.
05/18/2022	Corrective Action Plan Requested and Due on 06/02/2022
05/18/2022	Special Investigation Report Sent

ALLEGATION:

Resident A eloped from MLK Road Home on 03-04-2022 and was struck by a vehicle on North Michigan Road. She passed away from the injuries she sustained. Concern that Resident A was not provided with adequate supervision from direct care staff members.

INVESTIGATION:

An *AFC Licensing Division – Incident / Accident Report* (IR) was received and reviewed by this consultant on 03-10-2022 indicating that Resident A came out of her room about 9:15 p.m. on 03-04-2022 complaining that her leg was hurting. According to the IR, Resident A had been given Tylenol at about 5:00 p.m. and it was too early to give her more later in the evening when she requested it. Resident A was denied Tylenol, so she allegedly headed back to her room. Shortly before 10:00 p.m. a different resident came out of their room and mentioned that there was a lot of lights at the end of the driveway. Direct care staff members immediately did a contact check according to the incident report and found that Resident A was not in her room. Direct care staff members walked down the driveway and were met by two firefighters who recognized Resident A as one of the residents at MLK Road Home. Emergency personnel/fire fighters informed direct care staff members that Resident A was struck by a vehicle and was deceased.

An unannounced on-site investigation was conduct on 03-10-2022 by licensing consultant Rodney Gill and AFC area manager Dawn Timm. Resident A's resident record was reviewed.

Resident A's *Annual Placement Checklist* was reviewed which indicated that Resident A was admitted into MLK Road Home on 02-14-2022. There was a *Psychiatric Evaluation* found in Resident A's resident record completed on 02-24-2022 by Community Mental Health Clinton-Eaton-Ingham MD Lauren Brown. Resident A's *Psychiatric Evaluation* indicated that MLK Road Home has cameras outside the home for safety and security

purposes and was also equipped with door chimes to protect the residents who may attempt to leave the facility without permission. Resident A's *Psychiatric Evaluation* stated that Resident A had a history of attempted elopement from care centers, as well as physical aggression, throwing objects, pacing, disruptive behavior, yelling, property damage, combativeness, scratching, biting, pinching, punching caregivers, elevated moods, expansive thoughts, delusions, and paranoia. The *Psychiatric Evaluation* further indicated that Resident A has a history of difficulty adapting to placements especially due to her language barrier and that Resident A disclosed during the evaluation that she was scared to sleep in her room at MLK Road Home. During the psychiatric evaluation, Resident A indicated that it makes her mad when direct care staff members attempt to use google translate or other apps to communicate with her. Resident A indicated that she was experiencing pain in her right knee and complained of ankle pain during the psychiatric evaluation.

Licensee designee Melissa Lynn Doss called to speak to me while conducting the on-site investigation. She disclosed that she happened to be on call on 03/04/2022. Ms. Doss stated that she received a call from direct care staff member Shamondra Harris around 10:00 p.m. indicating that Resident A had eloped from the facility, was struck by a vehicle, and was deceased. Ms. Doss said she was told direct care staff members last saw Resident A in the facility between 9:15 p.m. and 9:30 p.m. Ms. Doss stated a resident told direct care staff members that there were a lot of lights out by the road, so they went out and began walking down the driveway to investigate. Two firefighters met them in the driveway and told them that Resident A had been struck by a vehicle and was deceased.

Ms. Doss stated that she was told that a 911 call came into central dispatch at approximately 9:42 p.m. reporting that an individual had been struck by a vehicle on Michigan Road near the intersection of Michigan Road and Columbia Road. Ms. Doss stated she did not speak with any first responders or police officers involved.

During the unannounced onsite investigation, I conducted a walk-through of the outside of MLK Road Home and observed six-foot chain-link fences on the north and south side of the facility. There is an exit door on both the north and southside of the facility where residents can exit in case of an emergency. There is a patio area on the northside of the building where residents can lounge and smoke. The fences were checked during the onsite investigation and the fence gate on the southside of the facility was locked but the fence on the northside was unlocked. The exterior door located on the southside of the facility had a door alarm chime that dinged or activated in the staff office when the door opened. The door on the northside of the building did not have a door chime affixed to it but it was designed to have an alarm connected to it. At the time of the unannounced on-site investigation, the alarm had been taken off unbeknownst to any direct care staff member working at the time. All direct care staff members stated that door should have had a working alarm at the time of the investigation and at the time Resident A eloped from the facility. Resident A's room was located at the end of the hallway on the northside of the building right next to the exterior door. The fencing around the facility leaves the facility fully enclosed thus

making the facility secured to any resident exiting off the north or south exits. The fence gate located on the southside was locked with a padlock whereas the northside fence gate was openable to residents using that area.

Direct care staff member Patricia Pickett was interviewed. She indicated that she worked 7:00 a.m. to 3:30 p.m. on 03-04-2022. Ms. Pickett stated Resident A was irritated and agitated on 03-04-2022. She said that Resident A was yelling and more upset than normal that day. Ms. Pickett stated she attempted to contact Resident A's Relative A1, who often interprets between direct care staff members and Resident A, to ask him to interpret for Resident A so direct care staff members would know why she was so irritated and agitated. She indicated that Relative A1's phone went to voicemail, she left a message, but he never called her back while she was working.

Direct care staff member Patricia Pickett indicated that Resident A required one-hour checks. She said that direct care staff members at MLK Road Home were required to check on and make eye contact with Resident A every hour. The shift logs were reviewed and were checked and initialed every hour under Resident A indicating direct care staff members were checking on and making eye contact with Resident A every hour on 03-04-2022.

Ms. Pickett stated that the direct care staff members at MLK Road Home could not understand anything that Resident A said, and that Resident A could not understand anything that they said either because English was not Resident A's first language. Ms. Pickett stated direct care staff members could not use writing as a communication option because English was not Resident A's first language and Resident A could not write in English. Ms. Pickett said that they did not have access to an interpreter and that Resident A's Relative A1 routinely would not answer his phone when they called him to interpret for Resident A. She stated that they would attempt to use google translate or other telephone apps to communicate with Resident A, but they did not work. Ms. Pickett stated the licensee designee had given direct care staff members a communication tool described as a piece of paper with pictures to use with Resident A but the instructions to use the tool were not helpful. Ms. Pickett did not indicate what was on the paper they were given.

Ms. Pickett stated that Resident A did not complain of pain in her leg when she was at the doctor's office on 02-28-2022 rather she was at the appointment for another medical reason. During this appointment however Ms. Pickett reported Resident A had x-rays taken of her leg due to previous complaints of it hurting. Resident A had recently been pushed by Resident B after getting out of the shower and the momentum that Resident B built when pushing Resident A caused her to fall on Resident A and predominantly land on Resident A's leg. She said that Resident A was complaining of pain in her leg on 03-04-2022 and was very upset. Ms. Pickett stated Resident A was so upset that she did not want to eat anything. She said that Resident A only ate a couple bites of food all day. Ms. Pickett stated that Resident A was given medication for pain, but direct care staff members could not satisfy her. Ms. Pickett stated that a direct care staff member scheduled an appointment for Resident A to see her primary care physician on

03-07-2022 due to the pain she was experiencing in her leg and to follow-up on the x-ray results.

Ms. Pickett stated that she had never seen Resident A elope from the facility nor heard Resident A attempted to elope from the facility before 03-04-2022. Ms. Pickett stated she never saw Resident A walking up and down the driveway for exercise or anything like that. She said that she works both day and/or night shifts at MLK Road Home and had not observed this behavior from Resident A. Ms. Pickett stated that she did find Resident A in the garage once and redirected her back inside the home.

Ms. Pickett stated that MLK Road Home has a chime on both the north and southside exterior exit doors. She said that the chimes go off and ding in the staff office when the doors are opened. Ms. Pickett was unaware that the chime closest to Resident A's bedroom was no longer affixed to the exit door and therefore was not working at the time of her elopement. Ms. Pickett expressed surprise that the chime was no longer on the door during the unannounced onsite investigation.

Ms. Pickett stated that she would have never thought Resident A would elope from the facility. She said that Resident A could be a difficult resident at times. Ms. Pickett stated that Resident A refused to take showers, had poor hygiene, refused to wash her clothes, hit, spit on, and touch direct care staff members and residents at times. Ms. Pickett said that Resident A would go outside and smoke occasionally when she was able to get another resident to give her a cigarette. Ms. Pickett indicated that most of the time though Resident A followed the rules and was pleasant to be around.
Ms. Pickett stated direct care staff members checked on Resident A on 03-04-2022 every hour from 7:00 a.m. to 9:00 p.m. She said that it is her understanding that the second shift direct care staff members last saw Resident A around 9:15 p.m.

Direct care staff member Mary Merz was interviewed via phone on 03-14-2022. She stated that Resident A was only at their facility for about a month. Ms. Merz stated that Resident A did not speak any English whatsoever and no one at MLK Road Home spoke Resident A's primary language. She said that the only way direct care staff members could communicate with Resident A was to contact Relative A1 and ask him to interpret for them. Ms. Merz stated that she called Relative A1 often, but he did not always answer his phone.

Ms. Merz stated that she worked the afternoon shift on 03-04-2022. She said that Resident A appeared agitated and upset that day. Ms. Merz stated that she called Relative A1 around 4:00 p.m. on 03-04-2022 and he answered the phone. Ms. Merz stated Relative A1 spoke to Resident A and she disclosed that her leg was hurting her. Ms. Merz stated that Resident A was prescribed Tylenol for pain, so she gave Resident A Tylenol after her conversation with Relative A1 ended.

Ms. Merz stated that Resident A was pushed by Resident B at the facility a few days before the incident on 03-04-2022. She said that Resident B was upset because Resident A had hit her first so there was a lot of tension between the two of them. Ms.

Merz stated the altercation happened after Resident A hit Resident B. She said that Resident A was coming out of the bathroom and the other resident came up and pushed her. Ms. Merz stated that after pushing Resident A, the other resident lost her balance and fell on top of Resident A. Ms. Merz stated when doing so, the other resident lost her balance and ended up falling on Resident A. She said that the other resident weighs a lot so there was concern of injury. Ms. Merz stated that direct care staff members helped to separate them and called emergency medical services. She said emergency medical technicians arrived on scene and examined Resident A for injury. Direct care staff members contacted Relative A1 who spoke to the emergency medical technician and declined having Resident A taken to the hospital.

Ms. Merz said that direct care staff members attempted to contact Relative A1 on 03-04-2022 again around 6:00 p.m. to ask him to speak to Resident A again because she remained agitated and was complaining of pain. She said that Relative A1 did not answer his phone at that time. Ms. Merz stated that later, around 8:00 p.m., she was doing contact checks and could not find Resident A. Ms. Merz found Resident A in the northside facing yard outside banging on the window of the activity room. Ms. Merz stated she was able to convince Resident A to come back inside the facility.

Ms. Merz stated that at approximately 9:00 p.m. she checked on Resident A again. She said that the light was off in Resident A's bedroom, so she used her flashlight and confirmed that Resident A was in her bed at that time. Ms. Merz stated that she then began cleaning the bathroom. She said that she found out that Resident A had come out of her room again after she checked on her at 9:00 p.m. and asked for more pain medication. Ms. Merz stated that the direct care staff member she asked told her that it was too soon to give her more Tylenol and the direct care staff member stated that Resident A went back to her room.

Ms. Merz said that around 9:50 p.m. another resident came out of their room and said, "Look at all of the pretty lights at the end of the driveway." Ms. Merz stated that direct care staff members walked toward the end of the driveway, were met by two firefighters that told them that Resident A had passed away. They indicated that they received a 911 call around 9:42 p.m.

Ms. Merz stated that they called Relative A1 around 11:30 p.m. and informed him of what had happened. She said that he was very upset that he was not called immediately. Ms. Merz stated that the alarms do not work and the chimes on the doors had not been working well and were not working well at the time of Resident A's elopement. Ms. Merz stated that direct care staff members had been trying to use Google translator to communicate with Resident A, but it never worked as an effective communication tool. She said that Resident A spoke too fast for the translating app to pick up what she was saying. Ms. Merz stated that Resident A was a good resident but would occasionally throw things at direct care staff members.

Ms. Merz stated that on a different date approximately a week prior to 03-04-2022, Resident A had left the facility and made her way down to the road. She said that this

happened during the day and a direct care staff member went after her in her car and was able to get her to come back to the facility. Ms. Merz stated that Resident A was right in front of the next-door neighbor's house when the direct care staff member picked her up. She said that the direct care staff member that went after Resident A and got Resident A to return to the facility was Shamondra Harris.

Ms. Merz stated that they had a debriefing regarding the incident at MLK Road Home on 03-11-2022 and were told then that Resident A had a history of elopement. She said that direct care staff members did not know that prior to the debriefing.

Ms. Merz stated that HCBS Waiver Program tells them what they can and cannot do with the residents. She said they are not allowed to have locked doors, gates, alarms, nor cameras at MLK Road Home per HCBS guidelines. Ms. Merz stated they were allowed to put chimes on the doors, but they never worked to begin with.

Direct care staff member Shannon Campbell was interviewed on 03-14-2022. She said the problem they had with Resident A was that she did not speak any English. Ms. Campbell stated that direct care staff members at MLK Road Home did hourly checks to ensure Resident A was okay and gave her medication as prescribed.

Ms. Campbell stated that Resident A had left MLK Road Home earlier in the day on 03-04-2022 and a direct care staff member was able to get her to come back inside the facility. She said that Resident A was just outside the facility looking in the window the first time she left. Ms. Campbell said that they did not know that she had left the facility again until around 9:00 or 10:00 p.m. when they saw the lights from the police, fire, and emergency vehicles.

Ms. Campbell stated that it was hard for them to communicate with Resident A. She said that direct care staff members could not understand her and she could not understand them. Ms. Campbell said that she does not understand why Resident A left the facility. She said that MLK Road Home is not a locked facility and that residents can leave when they want. Ms. Campbell stated that HCBS Waiver Program requested that they shut the alarms off at MLK Road Home, so they were not on the night Resident A left the facility.

Ms. Campbell said that direct care staff members were not equipped to meet the needs of Resident A as direct care staff members were unable to communicate with Resident A and never knew what she wanted. Ms. Campbell stated that direct care staff members are unable to keep eyes on every resident every minute of the day at MLK Road Home. Ms. Campbell stated that she knows that Resident A's leg was hurting her on 03-04-2022 and direct care staff members were giving her Tylenol for pain as prescribed by her doctor. She also knows that a direct care staff member had to tell Resident A that she could not get more pain medication around 8:00 p.m. that day. Ms. Campbell stated that Resident A was in the room nearest to the exit door on the northside of the facility because it was the only room they had open upon her admission to the facility. She said that without the alarms, gates being locked, and/or other

safeguards in place, direct care staff members were unable to know where Resident A was at every minute of the day.

Direct care staff member Kerry Thelen was interviewed on 03-14-2022. Ms. Thelen stated that she worked at MLK Road Home on 03-04-2022 and she knew that something was wrong with Resident A that day. She said that the problem was no one could understand her. Ms. Thelen stated that she found out during a debriefing session held at MLK Road Home on 03-11-2022 that Resident A had a history of elopement from previous places she resided at according to information obtained from her file. She said that is why direct care staff members checked on her every hour. Ms. Thelen said that it was dangerous for Resident A to be at MLK Road Home because they had to turn their alarms off because it was against the residents' rights to have them activated. She said Relative A1 thought that MLK Road Home was a locked facility.

Ms. Thelen said that Resident A kept asking to talk to Relative A1 on 03-04-2022. She said that Resident A was complaining she had pain in her leg. She kept telling Relative A1 that she was experiencing pain in her leg. Ms. Thelen stated that she made an appointment for 03-07-2022 to get Resident A's leg examined and x-rays taken. She said that Resident A was not seen holding her leg, but she was limping on 03-04-2022. She said that Resident A kept saying Relative A1's name on 03-04-2022, was motioning to her leg, and making faces and acting like she was in pain. Ms. Thelen stated that generally Resident A used to smile a lot and was in a good mood most of the time.

Direct care staff member Shamondra Harris was interviewed on 03-14-2022. She said that she worked second shift at MLK Road Home on 03-04-2022. Ms. Harris stated that the biggest problem that direct care staff members at MLK Home Road had with Resident A was the inability to communicate with her. She said that direct care staff members attempted to utilize technology to help communicate with Resident A, but Google Interpreter and other apps did not help. Ms. Harris stated that she understood Resident A's frustration with not being understood. She said that Resident A could not tell direct care staff members how she was feeling and specifically was unable to let them know how painful her leg was.

Ms. Harris stated that direct care staff members were informed that Resident A had a history of elopement from other places she resided during a debriefing at MLK Road Home on 03-11-2022. She said that MLK Road Home is not a locked facility, and it was not safe for Resident A to reside there given her history of eloping.

Ms. Harris stated that still the biggest problem was the lack of ability to communicate with Resident A. She said that direct care staff members would often call Relative A1 to ask if he could interpret what Resident A was saying or agitated about. Ms. Harris stated that the nephew did not answer his phone a lot and did not return voicemail messages.

Ms. Harris stated that Resident A previously attempted to elope from MLK Road Home on 02-18-2022. She said that Resident A left during the day on that date. She said that

she found out that Resident A wanted to get to Relative A's home. Ms. Harris stated that she was able to get Resident A to return to the facility. Ms. Harris stated that Resident A would get so frustrated at times that she would spit and swat at direct care staff members. Ms. Harris said that she knows that four previous residents at MLK Road Home have been struck by vehicles and three of them passed away from their injuries. She said that it is not safe for any resident with the history of eloping to be placed at MLK Road Home. A review of the MLK Road Home licensing file was conducted and there was no reported history or record of four previous residents being involved in pedestrian/vehicle accidents. This review includes investigations from the preceding three years (2019 until present).

Ms. Harris stated that they used to be able to lock the gates in the fenced in areas and had an active alarm system. She said that she was told HCBS Waiver Program had them unlock the gates and turn their alarms off. She said residents are now able to do what they want and can leave the facility whenever they want.

Ms. Harris said that Resident A was upset on 03-04-2022 because her leg was in pain. She said that a week or two before 03-04-2022 that Resident A was pushed down by another resident and the other resident fell on her. Ms. Harris stated that the night of 03-04-2022 Resident A wanted pain medications again after 8:00 p.m. and she had to let her know it was too early to give her more medication based on the doctor's order. She said that she tried keeping Resident A in the common areas so that she could keep an eye on her because she could tell the Resident A was agitated and she was in pain. Ms. Harris said that she wanted Resident A to prop her leg up and other techniques to help relieve the pain. Ms. Harris stated that Resident A went back to her room and the next she heard there were lights from police, fire, and emergency vehicles flashing from the road out in front of their facility. She said they walked down the driveway and two fire fighters let them know that Resident A had been struck by a vehicle while attempting to cross North Michigan Road and passed away from her injuries.

I interviewed Relative A1 was interviewed on 03-30-2022. Relative A1 said he does not know what happened to Resident A. He said that he does not understand how Resident A could have gotten out of the facility and made it to the road without any direct care staff members noticing. Relative A1 indicated that it was his understanding that residents at the facility would have to pass by the staff office to get outside. He said that Resident A had a history of schizophrenia and eloping from previous facilities. Relative A1 stated that he thought that MLK Road Home was a locked facility and that they had alarms, fences with locks, and camera surveillance to ensure that residents were unable to elope.

Relative A1 stated that law enforcement informed him that something like this previously happened at MLK Road Home and yet no steps have been taken to secure the property to keep the residents safe. Relative A1 said that he has still not been contacted by anyone from MLK Road Home letting him know how this happened. He said that no one has called to say they are sorry or to let him how Resident A was able to leave the

facility and get hit by a vehicle. Relative A1 stated that he was at the facility twice and that he was concerned that the doors to the entrances were not locked.

Relative A1 stated that he was made aware of an altercation that took place between Resident A and another resident at MLK Road Home approximately three weeks before Resident A passed away. He said that he was called and told that another resident pushed Resident A down as she was coming out of the bathroom, and that the other resident ended up losing their balance and falling on Resident A's leg. Relative A1 stated that it did not sound like she needed to go to the hospital at the time.

Relative A1 stated that Resident A did call him a couple hours before eloping from the facility on 03-04-2022. He said that she was complaining that her leg hurt. He said that a direct care staff member told him that she had a follow up doctor's appointment scheduled for 03-07-2022 to examine her leg and have it x-rayed. Relative A1 stated that Resident A previously saw a doctor and had x-rays taken of her leg. He said that Resident A told him that she would be able to handle the pain on 03-04-2022.

Relative A1 stated that Resident A and direct care staff members would call him often to help with communication between her and the direct care staff members. He said that he knew that direct care staff members were attempting to use Google translator, but he knows it is not usually accurate.

The Michigan Department of State Police *Original Incident Report* involving Resident A's elopement from MLK Road Home and subsequent events that followed leading to her passing was reviewed. The report confirms that the claims being investigated as part of this Special Investigation and information and timeline laid out in the Incident Report provided to the Licensing Unit are true and accurate.

Direct care staff member Mary Merz was interviewed via phone on 05-05-2022. She reported licensee designee Melissa Doss facilitated the debriefing held on 03-11-2022. The debriefing was held to discuss the circumstances surrounding the elopement and subsequent death of Resident A. Ms. Merz stated Melissa Doss held the meeting along with the direct care staff members working the day of Resident A's death and Resident A's case manager.

Ms. Merz had previously stated that Resident A had left the facility once prior to 03-04-2022 and made her way down to the road. Ms. Merz disclosed on 05-05-2022 that there were no additional safety measures enacted after Resident A initially eloped from the facility approximately a week prior to 03-04-2022. She said that direct care staff members continued with hourly checks and attempted to be more mindful of Resident A's whereabouts after the initial elopement.

Ms. Merz stated that direct care staff members are provided with a resident's basic information prior to the new resident arriving at MLK Road Home. She reiterated that direct care staff members were not informed that Resident A had a history of eloping from previous placements until the debriefing on 03-11-2022. Ms. Merz also reiterated

the frustration felt by direct care staff members and Resident A due to the language barrier and inability to communicate. She said that she is unsure if Resident A had an *Assessment Plan for AFC Residents* in her resident record. She stated that she could not recall.

I attempted to interview licensee designee Melissa Doss on both 05-04-2022 and 05-05-2022 however she did not return any telephone calls.

Licensee designee Melissa Doss was interviewed via phone on 05-13-2022. Ms. Doss stated that MLK Road Home does not have any specific process or training in place to prepare and enable direct care staff members to meet the needs of new residents upon admission. She said that Resident A came to the home with more extensive barriers to care than most residents that are placed at MLK Road home. This mainly included Resident A's language barrier. Ms. Doss stated that with Resident A they spoke with Jen Briere the hospital liaison for CEI- Community Mental Health prior to Resident A's admission to discuss the language barrier as Resident A only spoke Arabic. Ms. Briere informed them that previous placements used the Google Translate telephone application and other similar 'apps' to attempt to communicate with Resident A. Ms. Doss stated that is what she instructed direct care staff members to do.

Ms. Doss said that she contacted Relative A1 when it was found that Google Translate and other similar apps were not successfully able to help direct care staff member communicate with Resident A and/or for Resident A to communicate with them. Ms. Doss stated Relative A1 would make himself available when necessary to assist as a translator between Resident A and direct care staff members. Ms. Doss reported according to Relative A1, Resident A spoke a very formal form of Arabic which was not easily detected by translator telephone applications (apps) and the apps did not translate her words well. Ms. Doss said that she instructed direct care staff members to reach out to Relative A1 when having difficulty communicating with Resident A from that point on.

Ms. Doss stated that there have not been any automobile/pedestrian accidents involving residents at MLK Road Home since she has been the licensee designee starting in November of 2019. Ms. Doss said that she knows there were previous automobile/pedestrian accidents involving residents at MLK Road Home prior to her becoming the licensee designee. She said that she does not know the names of the resident victims, time, and date of the incidents, nor any additional information that would help to locate documentation related to these incidents.

Ms. Doss was asked to send Resident A's written Assessment Plan for AFC Residents (assessment plan). She said that she has access to Resident A's assessment plan from Community Mental Health and would email it to me. Ms. Doss stated that it would take some time and effort to locate Resident A's *Assessment Plan for AFC Residents* and there is not a lot of details added to this form as direct care staff members and other staff use the assessment plan from Community Mental Health when looking at the

needs of a specific resident. The *Assessment Plan for AFC Residents* was not received from licensee designee Melissa Doss at the time of the issuance of this report.

Ms. Doss stated that they are supposed to have cameras positioned outside in front of every exterior door. She said this is mainly to see who is outside and ensure that no one breaks into the home. Ms. Doss stated that MLK Road Home is in the process of getting a new camera system and she is unsure which cameras are currently in place and operational or were operational when Resident A eloped.

Ms. Doss said that HCBS will not allow them to have cameras inside the AFC home nor have alarms because that is against the residents' individual rights. She said that they are not able to monitor when residents leave the home. Ms. Doss stated that they did have chimes on the north and south side exit doors, but she was unsure if they were remounted and/or operational when Resident A eloped. Ms. Doss said that the chimes just quietly go off in the direct care staff members office when they are operational. I informed Ms. Doss that the exit door on the northside of the building did not have a chime mounted on it when an unannounced onsite investigation took place 03-10-2022. Resident A's room was located at the end of the hall on the north side of the building. Ms. Doss stated that there was nothing in Resident's A's assessment plan that required cameras or alarms to be operational at MLK Road Home to ensure her safety.

Ms. Doss stated that she did hold a debriefing (critical incident review) at MLK Road Home on 03-11-2022 with direct care staff members after the incident involving Resident A.

Ms. Doss was informed that a six-month provisional license is recommend given the outcome of this investigation. She said that she understood and is willing to cooperate fully with the requirements of a provisional license.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety needs, shall be attended to at all times in accordance with the provisions of the act.

ANALYSIS:	Based on documentation reviewed in Resident A's resident record, interviews with direct care staff members working at MLK Road Home, and review of the Michigan Department of State Police Original Incident Report, it has been established that direct care staff members working on 03-04-2022 recognized that Resident A appeared agitated, upset and in pain most of the day before she eloped and was involved in a pedestrian/vehicle accident ending in Resident A's death. Even after providing Tylenol to Resident A in an attempt to ease her pain, Resident A's demeanor did not improve yet no other medical intervention was taken to help determine Resident A's pain. Further, the alarm with chime located on the north exit near Resident A's door had been dismantled and was not working at the time she eloped from the facility on 03-04-2022, despite Resident A's *Psychiatric Evaluation* clearly documenting Resident A history of elopement and Resident A's elopement from MLK Road Home on/about 02-18-2022. Although multiple direct care staff members stated the facility was not allowed to secure the facility, the southside fence was locked and the door chime affixed to the south facing exit was working at the time of the unannounced on-site investigation on 03-10-2022. This left one side of the building secured but not the other side of the building where Resident A's room was located. Additionally, Resident A's *Psychiatric Evaluation* dated 02-24-2022 and completed by Community Mental Health Clinton Eaton Ingham MD Lauren Brown clearly outlined Resident A's history of elopement from previous facilities. Despite the information being readily available in Resident A's resident record, direct care staff members reported not learning about Resident A's history of elopement until after her death during a debriefing run by licensee designee Melissa Doss. Further, licensee designee and administrator Melissa Doss stated there was no training process in place to train direct care staff members about the personal care and behavioral needs of new residents. Consequently, Resident A's protection and safety needs were not attended to after direct care staff members were not aware of Resident A's needs for additional supervision due to elopement, the facility had taken no additional steps to assure Resident A's safety after her elopement on/about 02-18-2022, nor was any significant action taken to assist Resident A to determine the root cause of her distress on 03-04-2022. Given the licensee did not assure direct care staff members were fully trained on Resident A's personal care and supervision needs at the time of admission, could not adequately communicate with Resident A due to a significant language barrier, and the

	licensee designee did not intervene after her elopement on 02-18-2022, Resident A's protection and safety needs were not attended to on 03-04-2022 leading to a serious accident causing death.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(1) Care and services that are provided to a resident by the home shall be designed to maintain and improve a resident's physical and intellectual functioning and independence. A licensee shall ensure that all interactions with residents promote and encourage cooperation, self-esteem, self-direction, independence, and normalization.
ANALYSIS:	Resident A's primary language was not English and based on interviews with multiple direct care staff members, communication with Resident A was difficult as she could not understand what direct care staff members said and vice versa. No direct care staff member working at the facility spoke or wrote in Resident A's primary language, so she had no one to communicate with at the facility. As stated in Resident A's *Psychiatric Evaluation*, the use of the Google translation application made Resident A's frustrated yet this was the communication tool regularly used by direct care staff members to communicate with Resident A. Given that the licensee designee did not ensure a consistent way for direct care staff members to communicate with Resident A that was accessible and successful, interactions with Resident A did not promote or encourage cooperation, self-esteem, self-direction, independence, and/or normalization as Resident A could not understand the language.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION:

During the unannounced on-site investigation and review of Resident A's resident records, I did not observe a completed *Assessment Plan for AFC Residents*. There was

no documentation in Resident A's resident record that this document had been completed.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	At the time of the unannounced investigation, there was no completed written assessment plan in Resident A's resident record as required.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon the receipt of an acceptable corrective action plan, a six-month provisional license is recommended

05/18/2022

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Rodney Gill Date
Licensing Consultant

Approved By:

05/18/2022

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Dawn N. Timm Date
Area Manager