GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 4, 2023

Toya Sparks
AH Roseville MC Subtenant LLC
One Town Square, Ste 1600
Southfield, MI 48076

RE: License #: AH500397563
Investigation #: 2023A1019006
American House Roseville

Dear Ms. Sparks:

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 (517) 284-9730.

Sincerely,

Elizabeth Gregory-Weil, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 347-5503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH500397563
Investigation #:	2023A1019006
Complaint Receipt Date:	12/13/2022
Investigation Initiation Date:	12/15/2022
Report Due Date:	02/12/2023
Licensee Name:	AH Roseville MC Subtenant LLC
Licensee Address:	C/O ReNew Reit One SeaGate Ste 1500 Toledo, OH 43604
Licensee Telephone #:	(248) 203-1800
Administrator and Authorized Representative:	Toya Sparks
Name of Facility:	American House Roseville
Facility Address:	17267 Common Road Roseville, MI 48066
Facility Telephone #:	(586) 933-1593
Original Issuance Date:	08/03/2020
License Status:	REGULAR
Effective Date:	02/03/2022
Expiration Date:	02/02/2023
Capacity:	50
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A left the facility without staff knowledge.	Yes
Additional Findings	No

III. METHODOLOGY

12/13/2022	Special Investigation Intake 2023A1019006
12/13/2022	Comment Complaint was forwarded to LARA from APS. APS denied the allegation and did not assign it for investigation.
12/15/2022	Special Investigation Initiated - Letter Emailed AR for additional information.
12/15/2022	Contact- Document Received Requested documentation received from AR.
12/15/2022	Inspection Completed BCAL Sub. Compliance

ALLEGATION:

Resident A left the facility without staff knowledge.

INVESTIGATION:

On 12/13/22, the department received a complaint alleging that on the previous day, Resident A left the facility and staff were unaware that she was gone. The complaint read that Resident A had walked over to a nearby business asking for a ride and that law enforcement brought the resident back to the facility.

On 12/13/22, administrator and authorized representative Toya Sparks submitted two separate incident reports to LARA pertaining to Resident A dated 12/12/22. The first incident report occurred at 4:30pm read:

> *This nurse received a call from staff stating that during rounds the resident was unaccounted for. There were no doors alarming and all doors were properly secured. The staff did an inside search and then an outside search where the*

resident was located right outside the back door from the breakroom hall. Resident immediately escorted into the community. MD and Family notified.

The corrective measures listed on the report read “Increase frequency of monitoring, monitor for exit seeking behavior, PCP to evaluate medications. Psych consult request. Will continue to monitor for any changes in condition or baseline behavior.”

The second incident report occurred at 5:15pm read:

This nurse received a call from staff stating they were getting residents for dinner and the resident was missing. The resident was last seen at approximately 445pm when she stated she was going to her room to use the restroom. There were no door alarms sounding and all doors were secured. The staff immediately started a search of the community and grounds. At approximately 546pm the staff stated they received a call from the Roseville police dispatch stating they have [Resident A] and are bringing her back to the community. Per the Roseville police officer, they received a call from an employee at LE COM stating a woman came in and stated she was lost and needed a ride to Grosse pointe. The officer searched her purse and found her daughters number, called her daughter who notified him that she is a resident at AH FP. Upon return, resident assessed by Wellness Director. No sign of pain or injury noted. Resident unable to state how she exited the community. No sign of psychosocial harm. Pleasantly confused. Resident was dressed in her sweat shirt, jeans, coat, shoes and socks.

The corrective measures listed on the report read:

Frequent checks increased, monitor for exit seeking behavior, PCP to evaluate medications. Psych evaluation requested. Will continue to monitor for any changes in condition or baseline behavior. Staff inserviced on monitoring exit doors until they have closed completely. 1:1 in place. 30 day notice given to responsible party.

Resident A’s service plan was reviewed. Prior to the two elopements, Resident A’s service plan read that Resident A has dementia, ambulates independently and has mild short and long term memory impairment. The service plan was updated on 12/7/22 to include “Frequent checks continued, monitor for exit seeking behavior, encourage resident to participate in life enrichment activities after dinner, PCP to evaluate medications. Will continue to monitor for any changes in condition or baseline behavior. Frequent checks and monitor her stability.” Following the elopement events, Resident A’s service plan was updated to read “Staff inserviced on monitoring exit doors until they have closed completely. 1:1 in place. 30 day notice given to responsible party.”

American House Roseville is a secured memory care building with alarmed and locked doors. Ms. Sparks reported that staff did not witness the elopements but in follow up correspondence, Ms. Sparks stated:

My conclusion is that a culinary staff member came through the double doors on the service hall with the meal carts, pushed the automatic door open button and did not watch to make sure no resident followed them through the door. I feel this happened twice in that period of time that they were bringing the dinner carts and the beverage carts to the floor.

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 A had two successful elopements on 12/12/22 that occurred within a short amount of time. Facility staff provided inadequate supervision to Resident A, placing her at significant risk of harm when unattended outside the facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

12/20/2022

Elizabeth Gregory-Weil Date
Licensing Staff

Approved By:

01/04/2023

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