GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 29, 2022

Katy Juarez
The Legacies ALC, LLC
8702 Orleans Ave
Fenwick, MI 48834

RE: License #: AL410393508
Investigation #: 2023A0357003
Legacies Assisted Living B1

Dear Ms. Juarez:

Attached is the Special Investigation Report for the above referenced facility. Due to the violation 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 responsible party and a date.

If you desire technical assistance in addressing these issues, please 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 (616) 356-0100.

Sincerely,

Arlene B. Smith

Arlene Smith, MSW, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 916-4213

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL410393508
Investigation #:	2023A0357003
Complaint Receipt Date:	11/03/2022
Investigation Initiation Date:	11/03/2022
Report Due Date:	01/02/2023
Licensee Name:	The Legacies ALC, LLC
Licensee Address:	8702 Orleans Ave Fenwick, MI 48834
Licensee Telephone #:	(616) 325-4309
Administrator:	Katy Juarez
Licensee Designee:	Katy Juarez
Name of Facility:	Legacies Assisted Living B1
Facility Address:	9031 B1 N. Rogers Ct. SE Caledonia, MI 49316
Facility Telephone #:	(616) 275-4999
Original Issuance Date:	03/25/2019
License Status:	REGULAR
Effective Date:	09/25/2021
Expiration Date:	09/24/2023
Capacity:	20
Program Type:	AGED, ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A was missing from the facility for approximately twenty minutes and staff were unaware she was missing.	Yes

III. METHODOLOGY

11/03/2022	Special Investigation Intake 2023A0357003
11/03/2022	Special Investigation Initiated - Telephone spoke by telephone with Roy Juarez, RN.
11/03/2022	APS referral.
12/27/2022	Contact - Telephone call made With Carrie Danks, Home Manager.
12/28/2022	Inspection Completed On-site.
12/28/2022	Contact - Face to Face Interview with Roy Juarez, RN and Carrie Danks, Home Manager. Interview with Direct Care Staff, Madeline Davis.
12/28/2022	Contact - Document Received Received documentation pertaining to Resident A.
12/29/2022	Exit conference by telephone with the Licensee Designee, Kathy Juarez.

ALLEGATION: Resident A was missing from the facility for approximately twenty minutes and staff were unaware she was missing.

INVESTIGATION: On 11/03/2022, I received an AFC Licensing Division – Incident / Accident report from Legacies Assisted Living B1. The report indicated that Resident A had left the facility unattended between 6:30 -7:30 PM and staff were unaware that Resident A had eloped from the facility.

On 11/03/2022, I telephoned Roy Juarez, R.N. He explained that Resident A had just moved into the facility on 11/01/2022. He indicated that Resident A has a diagnosis of late onset of Alzheimer's. He explained that on 11/02/2022, it was very windy, and this had caused the exit doors to open and send off door alarms. He stated the staff checked all the doors that had been opened by the wind and closed them for security. He stated that the door at the end of the south hallway had

alarmed, and the staff checked the door and had gone outside and looked around to see if anyone was outside and not seeing anyone, they secured the door. He reported that the home received a call from the local D&W grocery store at 7:28 P.M. reporting that they had an individual in their store that they thought had come from their facility. Direct Care Staff, Toni Garcia, immediately went to pick up Resident A and brought her back to the facility and then notified the Designated Representative, the resident's daughter. He stated that they checked Resident A all over and found no injuries. They took Resident A's, Blood Pressure, Pulse, Pulse ox and her temperature, which were all normal. He stated that Resident A had attended their supper meal that evening and then went to go to her room, and it appeared that she turned right at the hall intersection instead of turning left to go to her room. She saw the door at the end of the south hallway, and she just went out the door. He reported that Resident A walks very fast and she went around the building next door, then past a store and the post office and then entered D&W. He explained that they would be doing an immediate Inservice for all the staff on how to complete a head count of all of the residents after a door alarm goes off to make sure all the residents are in the facility. Mr. Juarez acknowledged that Resident A had left the facility without the staff's knowledge for a period of time. He stated that he estimated that the last time that staff saw her was after supper and that she was gone from the facility for about 30 minutes. Mr. Juarez stated that he immediately changed Resident A's assessment plan to state: *'Resident more confused at risk for elopement and wandering.'*

On 11/03/2022, the Incident/Accident report under section of "Corrective Measures Taken to Remedy and/or Prevent Recurrence," read as follows: *'Staff to escort Resident to room after dinner and turn on her radio. Will offer Memory Care to family. Resident only at facility for 24 hours upon admission. Family denied any exit seeking or wondering behaviors.'*

On 12/27/2022, I telephoned Carrie Danks, Home Manager and we discussed interviewing the direct staff who had worked the evening of 11/02/2022. She explained that the staff, Toni Garcia no longer works at the facility. She reported that I could interview Direct Care Staff, Madeline Davis on 12/28/2022 as she was assigned to work the second shift.

On 12/28/2022, I reviewed Resident A's assessment plan. Under the section entitled "Comments" the following was written: *'Per family resident is forgetful, not exit seeking or wandering behavior.'* There was a new entry dated 11/3/2022 that read: *'Resident Sundown's in the evening and becomes more confused, prone to wandering. Staff to escort Resident to room and turn on CD player after dinner.'*

On 12/28/2022, I made an announced inspection of the facility. I met with Roy Juarez, R.N. and with Carrie Danks. Mr. Juarez explained that Resident A's Designated Representative, had failed to report to them during the interview process for admission to their facility of their concerns and knowledge of Resident A's wanderings. They also did not provide information that Resident A has serious

“Sundowning symptoms,” occurring anywhere around 3:00, 4:00 or 5:00 P.M. in the evenings. Mr. Juarez stated that since then, they have secured help from Psychological Services that have prescribed Seroquel, and this has helped Resident A to some degree.

On 12/28/2022, Mr. Danks took me to meet Resident A, but she was visiting with her family and other residents. I was able to observe her. She was confused and repeating herself during the conversation she was having with other residents and her family member. Ms. Danks reported that Resident A asks every day ‘Where am I?, Why am I here ?, When will I go home?” She stated that staff have to take Resident A to her room and remind her that these are her belongings in her room and then she accepts that this is her room. Ms. Danks reported that Resident A has not sought to leave the facility since the 11/02/2022, incident. Resident A was unable to contribute to the investigation due to her diagnosis.

On 12/28/2022, I conducted an interview with Direct Care Staff, Madeline Davis. She reported she has worked for the facility for 1 ½ years and she confirmed that she is fully trained. I asked her to explain what happened on 11/02/2022 and she reported that she was the medication passer that second shift and was working with Toni Garcia who was only on her third day of employment. She stated that their dinner/supper time is 5:00 P.M. and the residents are finished around 6:00 P.M. and they return to their rooms or visit with each other. She stated that it was extremely windy that day and the wind caused the security doors to open, and they have an app on their phones to notify them what door had opened. She reported that she and the other staff had checked each door that had opened and then they secured it. She reported that the south exit door had opened, and Ms. Garcia had walked to the door and then walked outside, looked all around, and did not see anyone so she came back in and secured the exit door. Ms. Davis stated that she was helping a resident by changing their catheter when Ms. Garcia knocked on the door and stated she needed to talk to her immediately. She spoke with Ms. Garcia who told her that D&W had just called the facility to inform them that they believed one of the residents was at their store. They provided a description of the individual and it was Resident A. Ms. Davis stated that Ms. Garcia went immediately in her car to pick up Resident A. Ms. Davis said that Ms. Garcia reported that the police were at the store. She confirmed that they completely evaluated Resident A and she was fine with no injuries. They also took all of her vital signs, and they were normal. I asked her how long she thought Resident A was absent from the facility. Ms. Davis estimated that she was gone between 30 to 45 minutes. She stated that Resident A was brand new to the facility and that the family of Resident A had not told them that she had wandered or that she was exit seeking. She also reported that Resident A is very quick when she is walking. She also stated this is the first time this has ever happened, and it has not happened since. She explained that there are signs up reminding staff what to do and they have been trained on what to do if a door is opened. They are required to count all the residents, check to see if any of the residents are signed out of the facility and this will assure that all residents are in the facility.

On 12/29/2022, I conducted a telephone exit conference with the Licensee Designee, Katy Juarez and she agreed with my findings.

APPLICABLE RULE	
R 400.15305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	On 11/02/2022 Resident A exited the facility without staff's knowledge and walked to a grocery store. The exit door at the end of the South hallway had been opened and the alarm went off. Staff reported they checked the outside area, but they did not find anyone. Mr. Juarez and Direct Care staff Madeline Davis estimate that Resident A was gone from 20 to 45 minutes. Staff brought Resident back to the facility where she was evaluated and found to be fine. During this investigation it was found that Resident A was absent without notice from the facility and therefore there is a rule violation established.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

I recommend that the Licensee provide licensing with an acceptable plan of correction.

Arlene B. Smith 12/29/2022

Arlene B. Smith, Licensing Consultant Date

Approved By:

12/29/2022

Jerry Hendrick, Area Manager Date