GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 23, 2023

Ginger Nahikian
Clare MI OPCO, LLC.
3405 E Midland Rd
Bay City, MI 48706

RE: License #: AL180404676
Investigation #: 2023A1029034
Niche Aging Clare I

Dear Ms. Nahikian:

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 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. 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 (231) 922-5309.

Sincerely,

Jennifer Browning

Jennifer Browning, Licensing Consultant
Bureau of Community and Health Systems
Browningj1@michigan.gov - (989) 444-9614

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL180404676
Investigation #:	2023A1029034
Complaint Receipt Date:	03/31/2023
Investigation Initiation Date:	03/31/2023
Report Due Date:	05/30/2023
Licensee Name:	Clare MI OPCO, LLC.
Licensee Address:	3405 E Midland Rd, Bay City, MI 48706
Licensee Telephone #:	(989) 386-7524
Administrator:	Chelsea Blain
Licensee Designee:	Ginger Nahikian
Name of Facility:	Niche Aging Clare I
Facility Address:	684 Ann Arbor Trail, Clare, MI 48617
Facility Telephone #:	(989) 386-7524
Original Issuance Date:	02/01/2021
License Status:	REGULAR
Effective Date:	08/01/2021
Expiration Date:	07/31/2023
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

ALLEGATION(S)

	Violation Established?
Resident A was able to exit Niche Aging Clare I around 2:30 a.m. on March 27, 2023 and was found outside the building.	Yes

II. METHODOLOGY

03/31/2023	Special Investigation Intake 2023A1029034
03/31/2023	Special Investigation Initiated – Letter to Chelsea Blain.
03/31/2023	APS Referral made to Centralized Intake
04/13/2023	Inspection Completed On-site – face to face with Chelsea Blain, Resident A, licensee designee Ginger Nahikian, Karmen Onweller, Ervanna Brugger at Niche Aging Clare I
04/20/2023	Contact - Telephone call made to direct care staff member Brianna Parker, Relative A1
05/04/2023	Contact - Telephone call made to direct care staff member Brianna Parker
05/16/2023	Exit conference with licensee designee, Ginger Nahikian

ALLEGATION:

Resident A was able to exit Niche Aging Clare I around 2:30 a.m. on March 27, 2023 and was found outside the building.

INVESTIGATION:

On March 31, 2023, an *AFC Incident / Accident Report* was sent to AFC Licensing Consultant Bridget Vermeesch documenting the following information: Resident A was found outside the facility on March 27, 2023 at 2:30AM on the sidewalk with scrapes on her knees and elbows. According to the *AFC Incident / Accident Report*, Resident A was brought back into the facility, warmed with a hot shower, and given Tylenol.

I reviewed the *AFC Incident / Accident Report* which include the following information:

"Explain what happened: Upon doing rounds resident was not observed in her bedroom, common area, bathroom, or other resident rooms.

Action taken by staff: Management and family were notified, conducted search of building, continued search on premises outside, and resident observed on sidewalk. Resident observed to have scrapes on knees and elbows and right toe. Resonant warmed with shower warm clothes and hot liquids and given PRN Tylenol.
Corrective measures: Obtain UA to roll out UTI related to confusion notify PCP immediately of change in baseline increased pain or inability to walk for further evaluation and treatment if indicated."

On April 13, 2022 I interviewed administrator, Chelsea Blain at Niche Aging Clare I. According to Ms. Blain, the incident occurred on March 27, 2023, when she received a phone call around 2:30 AM from direct care staff member, Ms. Parker who informed her Resident A was not in her room when Ms. Parker was doing her rounds. Ms. Blain stated Resident A has never tried to leave the facility before but she has seemed more confused than usual. Ms. Blain stated Resident A's primary doctor is Renee Doherty through Careline Physician Services and she was notified. Ms. Blain stated there are alarms on all the doors and Resident A resides in the locked memory care area. Ms. Blain stated when this incident occurred Ms. Parker last checked on Resident A at 12:50 and she was sitting at her desk chair.

During the on-site investigation, I reviewed Resident A's resident record. According to her *Health Care Appraisal* completed on January 10, 2023, she is diagnosed with vascular dementia, emphysema, DM2, shoulder pain, depression, anxiety, hypertension, and interstitial cystitis. There was documentation on the Health Care Appraisal that she was susceptible to hyper/hypothermia "per disease process." According to Resident A's *Assessment Plan for AFC Residents*, Resident A does not have the ability to move independently in the community and is "pleasantly confused at times."

I reviewed charting notes for Resident A with the following documentation written by Ervanna Brugger on March 26, 2023 at 2:55 a.m.:

"Resident observed outside with a shawl, purse, and clogs on. Resident brought in and wrapped in warm blankets, given coffee, and showered. Family aware. Managers arrived at facility to ensure resident was free of frostbite as undetermined amount outdoors. Resident free of frostbite. Resident was going to see her sister."

On April 13, 2023 I interviewed Resident A at Niche Aging Clare I. Resident A stated she did not remember trying to leave the facility in the middle of the night and she has never seen anyone trying to go out of the doors. Resident A stated she knew there was alarms on all the doors and the alarms go off during the day and night. Resident A has never seen the doors propped open so someone could leave. Resident A stated she does not know how many staff were working but typically she can call out for help, and they will be there quickly. Resident A stated she was surprised that there is no alert button she can wear to call staff when needed. Resident A stated the facility "does not

have a prison atmosphere, where people are trying to escape." Resident A stated she is happy living at this facility.

On April 13, 2023, I interviewed licensee designee Ginger Nahikian. Ms. Nahikian stated she did not know what door Resident A left from in the middle of the night and stated Resident A has not tried to leave the facility before. Ms. Nahikian showed each exit door and all alarms were working at the time of the inspection. I observed one door located off the kitchen that leads to the hallway, one that goes out the front of the building through a food pantry, and the other at the end of Resident A's hallway that leads to the side of the building. Although the side door is the closest door to her room, she was found on the other side of the building on the sidewalk outside closest to the door leading off the kitchen. I also observed all three of these doors are equipped with alarms and the door off the kitchen, includes a sign which states, "Push until alarm sounds. Door can be opened in 15 seconds."

On April 13, 2023, I interviewed direct care staff member Karmen Onweller. Ms. Onweller stated she does not know how Resident A left the building in the middle of the night because all the door alarms are working. Ms. Onweller stated she has never noticed the doorways propped open. Ms. Onweller stated Resident A has mentioned leaving the facility in the past when she is confused but she has never tried to leave and direct care staff members can redirect her.

On April 13, 2023, I interviewed Ervanna Brugger, RN. RN Brugger stated she received the call in the middle of the night when Resident A left the building and she came in so she could make sure she did not have frostbite since it was a cold night. RN Brugger stated Resident A was still pretty cold so they gave her coffee and put blankets on her. RN Brugger stated when she arrived Resident A's temperature was 96.5 and it quickly raised 97.9. RN Brugger stated at times Resident A would come out and be looking for her family but the facility staff has always been able to redirect her. RN Brugger stated she has never observed Resident A trying to leave the facility and thought Resident A used the middle doors by the kitchen to elope. RN Brugger stated the doors are never propped open unless they are bringing in groceries and then there is always a staff member present.

On April 20, 2023, I interviewed Relative A1. Relative A1 stated he went there the next day and Resident A had no recollection of being outside at all but she was aware she had a fall but did not recall when due to her dementia diagnosis. Relative A1 stated he was contacted by the facility director, Chelsea Blain around 4:00 a.m. saying they found Resident A outside on the sidewalk after she was not in her room during the room check. Relative A1 stated that Resident A does tend to wander at night. Relative A1 stated he was told she tried to leave out the side door which is alarmed but the door was not fully engaged and she was able to get outside. Relative A1 stated he has never been there and observed the doors not engaged. Relative A1 stated Ms. Blain came onsite and helped to locate her. Relative A1 stated he was not aware of her trying to go outside the building in the past and this is an isolated incident. Relative A1 stated he had no concerns regarding the care or supervision at Niche Aging Clare I.

On May 4, 2023, I interviewed direct care staff member Brianna Parker. Ms. Parker stated she noticed Resident A was not in her room between 2:00 a.m.- 2:30 a.m. so she called her managers and three of them showed up to the facility. Ms. Parker stated Resident A was found outside on the sidewalk near the front of the building and she came back into the building around 3:15 a.m. Ms. Parker stated the direct care staff member complete room checks during their rounds every two hours at midnight, 2:00 a.m., 4:00 a.m., and 6 p.m. Ms. Parker stated she noticed Resident A was not in her room at 2:00 am because at midnight she was in her room sitting in her chair. Ms. Parker stated Resident A was cold when she came back in and had scrapes on her knees but otherwise appeared fine. Ms. Parker stated she thinks she walked out the side door near the kitchen leading to a hallway and a main front door which was not locked. Ms. Parker stated she could not have exited through the pantry because there is a code to the door. Ms. Parker stated if Resident A used the side door that exits to the hallway, she would have been able to go into the foyer and then to the front door. Ms. Parker stated at the time Resident A left the building, the alarm was off on the first door leading to the hallway, the door at the end of the hallway had an alarm that was always on, and the pantry door requires the direct care staff member to enter a code. Ms. Parker stated she did not know why the alarm was off on the side door or why it was not latched all the way but when Resident A left the building she would have had to go through two doors to leave. Ms. Parker stated this door sometimes does not latch all the way unless it is pushed closed and someone may have not done so. Ms. Parker stated she was on that side of the building when she was found. Ms. Parker stated they now always make sure the door always latches each time. Ms. Parker stated after this incident she had increased her nightly checks after this incident and will check on Resident A every ½ hour to 1 hour to make sure Resident A is still in her room.

APPLICABLE RULE	
R 400.15303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Resident A was not provided supervision according to her *Assessment Plan for AFC Residents* because she was able to leave the facility around 2:00 a.m.. Resident A has a diagnosis of dementia and resides is in a secure part of the facility however, the door was not completely latched thus allowing Resident A was able to leave the building in the middle of the night. Resident A was found at 2:30 a.m. on the sidewalk outside of the facility and with a body temperature of 96.5 degrees with scratches on her knees, elbow, and toe.
CONCLUSION:	**VIOLATION ESTABLISHED**

III. RECOMMENDATION

Upon receipt of an approved corrective action plan, I recommend no change in the license status.

Jennifer Browning
Licensing Consultant

05/16/2023
Date

Approved By:

05/23/2023
Date

Dawn N. Timm
Area Manager