GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 21, 2023

Caroline Anderson
Essence Memory Care II LLC
3910 Athens Ave
Waterford, MI 48329

RE: License #: AS630405613
Investigation #: 2023A0993026
Essence Memory Care II

Dear Mrs. Anderson:

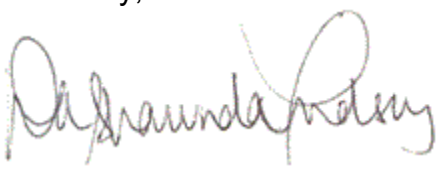
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (248) 975-5053.

Sincerely,



DaShawnda Lindsey, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste. 9-100
Detroit, MI 48202
(248) 505-8036

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630405613
Investigation #:	2023A0993026
Complaint Receipt Date:	05/09/2023
Investigation Initiation Date:	05/10/2023
Report Due Date:	07/08/2023
Licensee Name:	Essence Memory Care II LLC
Licensee Address:	3910 Athens Ave Waterford, MI 48329
Licensee Telephone #:	(248) 308-9607
Administrator:	Drita Aliatim
Licensee Designee:	Caroline Anderson
Name of Facility:	Essence Memory Care II
Facility Address:	22208 Wingate Ct Farmington Hills, MI 48335
Facility Telephone #:	(248) 308-9607
Original Issuance Date:	12/21/2020
License Status:	REGULAR
Effective Date:	06/21/2021
Expiration Date:	06/20/2023
Capacity:	6
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Earlier this morning on 04/15/2023, around 4:30am, Resident A went to use the bathroom then decided to leave the facility through the front door. She made it down a half of block and was found by the fire department.	Yes

III. METHODOLOGY

05/09/2023	Special Investigation Intake 2023A0993026
05/09/2023	APS Referral Received allegations from adult protective services (APS). The assigned APS specialist is Ra'Shawnda Robertson.
05/10/2023	Special Investigation Initiated - On Site Conducted an unannounced onsite investigation
05/10/2023	Contact - Telephone call made Telephone call made to APS specialist Ra'Shawnda Robertson
06/06/2023	Contact - Telephone call made Telephone call made to home manager Jessica Simps
06/06/2023	Contact - Telephone call made Telephone call made to staff Andrea Harrison
06/06/2023	Contact - Telephone call made Telephone call made to Resident A's guardian (and son). Left a message.
06/06/2023	Contact - Telephone call made Telephone call made to Resident A's guardian (and son)
06/06/2023	Contact - Document Sent Requested a copy of the police report
06/12/2023	Contact - Document Received Received a copy of the police report
06/13/2023	Exit Conference Held with licensee designee Caroline Anderson

ALLEGATION:

Earlier this morning on 04/15/2023 around 4:30am, Resident A went to use the bathroom then decided to leave the facility through the front door. She made it down a half of block and was found by the fire department.

INVESTIGATION:

On 05/09/2023, I received allegations from adult protective services (APS). The assigned APS specialist is Ra'Shawnda Robertson.

On 05/10/2023, I conducted an unannounced onsite investigation. I interviewed staff Hailee Howard, staff India Harris, and staff Shaniya Sanders.

Ms. Howard verified Resident A left the facility without staff. Ms. Howard did not know who was working at the time of Resident A's elopement. Per Ms. Howard, Resident A does not get up and walk out a lot. However, she will try to. Due to Resident B's elopement risk, there must be staff with her always.

Ms. Harris stated she was not working when Resident A eloped from the facility. She did not know which staff was working. Ms. Harris stated Resident A does not try to elope from the facility often. She verified Resident A cannot move independently in the community.

Ms. Sanders stated she was not working when Resident A eloped from the facility. She believed staff Andrea (last name not identified) was working at the time of Resident A's elopement. Ms. Sanders stated Resident A does not try to elope from the facility often. She verified Resident A cannot move independently in the community.

During the investigation, I observed Resident A but was unable to interview her due to her limited cognitive abilities. I observed Resident A get up from a recliner in the living room and walk out of the front door. One of the staff followed her. I also observed an alarm on the front door that sounds/beeps when the door is opened.

While at the facility, I reviewed Resident A's assessment plan. Per the plan, dated and signed on 08/20/2022, Resident A uses a cane and cannot move independently in the community. I also reviewed the incident report (IR). Per the IR, on 04/15/2023 at 5:25am, police located Resident A sitting in the yard four houses away from the facility. EMS examined the resident. No physical injuries or emotional distress were noted. Resident A was returned to the facility without incident. Due to the incident, staff will no longer do laundry during times when only one staff is present in the facility. It is noted in the IR that the front door alarm is functional but could not be heard in the basement.

On 05/10/2023, I conducted a telephone interview with APS specialist Ra'Shawnda Robertson. Ms. Robertson stated staff Andrea Harrison was working when Resident A eloped from the facility. Ms. Harrison was doing laundry a d did not hear Resident A leave out of the facility. She observed the front door open. When she checked on the residents, she noticed that Resident A was gone. Ms. Harrison called 911 and the managers. Resident A was returned by police.

On 06/06/2023, I conducted a telephone interview with home manager Jessica Simps. Ms. Simps stated the staff who working when Resident A eloped from the facility no longer works in the facility. Per Ms. Simps, she was informed staff went to the basement to switch laundry. She came back up and checked on everyone. She noticed Resident A was missing. She notified home manager, licensee designee Colleen Cassidy as well as called 911. Resident A was found by Farmington Hills police about 45 minutes later. This was the first time Resident A eloped from the facility.

On 06/06/2023, I conducted a telephone interview with staff Andrea Harrison. Ms. Harrison verified she was working during the time Resident A eloped from the facility. Per Ms. Harrison, she went in the basement to do laundry. When she came back upstairs, she observed the front door open. She checked all the bedrooms and noticed that Resident A was missing. She called her boss and 911. Police located Resident A about 20 to 30 minutes later. Ms. Harrison stated that was the first time Resident A eloped from the facility.

On 06/07/2023, I conducted a telephone interview with Resident A's guardian (and son). Resident A's guardian stated he was aware that Resident A eloped from the facility in April 2023. That was the first time Resident A eloped from the facility. Resident was admitted into the facility in August 2022. Per Resident A's guardian, Resident A has not tried to elope from the facility since the incident in April. He stated he did not have any concerns about the care Resident A receives in the facility.

On 06/12/2023, I reviewed a copy of the police report. Per the report, Farmington Hills was dispatched on 04/15/2023 due to a missing person. Police spoke with Ms. Harrison and Ms. Cassidy. Ms. Harrison stated she checked on Resident A around 4:50am and discovered that Resident A had walked out of the door. She contacted Ms. Cassidy and 911. Approximately 35 minutes later, police located Resident A and released her into the care of Ms. Cassidy.

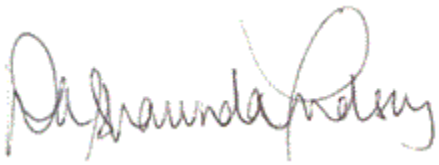
On 06/13/2023, I conducted a telephone interview with licensee designee Caroline Anderson. I informed her of the findings. She agreed to submit a corrective action plan.

APPLICABLE RULE	
R 400.14303	**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:	On 04/15/2023, Resident A eloped from the facility while Ms. Harrison was in the basement during laundry. Farmington Hills police located Resident A about 35 minutes later and released her into the care of Ms. Cassidy. Per Resident A's assessment plan, Resident A cannot move independently in the community.
CONCLUSION:	**VIOLATION ESTABLISHED**

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, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	On 04/15/2023, Resident A eloped from the facility while Ms. Harrison was in the basement doing laundry. Farmington Hills police located Resident A about 35 minutes later and released her into the care of Ms. Cassidy. Resident A has limited cognitive abilities and cannot move independently in the community. Due to the incident, staff will no longer do laundry during times when only one staff is present in the facility. It is noted in the IR that the front door alarm is functional but could not be heard in the basement.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

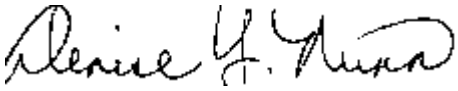
Contingent upon the receipt of an acceptable corrective action plan, I recommend no change in the license status.



06/13/2023

DaShawnda Lindsey — Date
Licensing Consultant

Approved By:



06/21/2023

Denise Y. Nunn — Date
Area Manager