GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 4, 2022

Michael Dyki - Blossom Springs
3215 Silverbell Rd.
Oakland Twp, MI 48306

RE: License #: AH630396969
Investigation #: 2022A1011002
Blossom Springs

Dear Mr. Dyki:

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 licensee authorized representative 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 (517) 284-9730.

Sincerely,

Andrea Krausmann, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street - P.O. Box 30664
Lansing, MI 48909
(586) 256-1632

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630396969
Investigation #:	2022A1011002
Complaint Receipt Date:	06/27/2022
Investigation Initiation Date:	06/28/2022
Report Due Date:	08/27/2022
Licensee Name:	Blossom Ridge, LLC
Licensee Address:	3005 University Drive Auburn Hills, MI 48326
Licensee Telephone #:	(248) 884-1404
Administrator:	Michael Dyki
Authorized Representative:	Michael Dyki
Name of Facility:	Blossom Springs
Facility Address:	3215 Silverbell Rd. Oakland Twp, MI 48306
Facility Telephone #:	(248) 601-0505
Original Issuance Date:	11/23/2020
License Status:	REGULAR
Effective Date:	05/23/2022
Expiration Date:	05/22/2023
Capacity:	56
Program Type:	AGED ALZHEIMERS

ALLEGATION(S)

	Violation Established?
Resident B suffered injuries, after staff opened door for him to exit facility and roam around unsupervised for more than an hour. A bystander found him in a pool of blood on the ground at a nearby church and called for help.	Yes
Resident B was not bathed twice weekly in accordance with his service plan.	No
Additional Findings	Yes

II. METHODOLOGY

06/27/2022	Special Investigation Intake 2022A1011002
06/28/2022	Special Investigation Initiated - Telephone Left voice mail message for authorized representative/administrator Mike Dyki requesting call back.
06/28/2022	Contact - Telephone call made Called facility left message with facility staff requesting Mr. Dyki return my call.
06/28/2022	Contact - Document Sent Email to assigned licensing staff Aaron Clum re: reporting of incident.
06/28/2022	Contact - Document Received Email from assigned licensing staff Aaron Clum, he could not recall specific date/time notification email.
06/29/2022	Contact - Telephone call made Interviewed authorized representative/administrator Mike Dyki and requested documentation be submitted via email.
06/29/2022	Contact - Document Sent List of documentation to be submitted sent to M. Dyki via email.
06/29/2022	Contact - Document Received Mike Dyki emailed 72 pages of documentation on one attachment and one video on the other attachment. I requested the 72 pages

	be broken down by document, as I am unable to review it in the current state.
06/30/2022	Contact - Document Received Mike Dyki submitted various documents as separate attachments to emails. Unfortunately, only the middle section of each page scanned in on the attachments. Left and right sides of each page could not be viewed nor printed, therefore, omitting significant amount of information on each page.
07/07/2022	Contact - Document Received Mike Dyki submitted Staff #1's employee information received.
08/01/2022	Contact - Telephone call made Interviewed reporting source (RS) that reported the matter to adult protective services (APS).
08/01/2022	Contact - Document Sent Returned documents to Mike Dyki as illegible. Only middle section of pages were scanned resulting in omission of right and left sides of documents.
08/01/2022	Contact - Telephone call made Interviewed Staff #1.
08/02/2022	Inspection Completed On-site Interviews conducted, observations made, records reviewed.
08/02/2022	Contact - Document Sent Request emailed to Oakland Co sheriff dept for their report.
08/03/2022	Contact - Document Sent Request to M. Dyki for video when police entered building, as it was not previously submitted.
08/03/2022	Contact - Telephone call made Left voice mail requesting call back from Staff #2.
08/03/2022	Contact - Document Sent Request to M. Dyki for status checks of Resident B from 6/13 to 6/20/22.
08/03/2022	Contact – Document Received M. Dyki submitted a photo of a police officer standing at the concierge desk with Staff #1 seated at the desk. It is date/time stamped 20220620 194434 [06/20/2022 7:44 pm (34 seconds)].

	M. Dyki did not submit the video as requested and wrote that the file was too large to send.
08/04/2022	Contact - Document Sent Second request to M. Dyki for status checks of Resident B from 6/13 to 6/20/22.
08/04/2022	Contact - Telephone call made Left voice mail requesting call back from Staff #1.
08/04/2022	Contact - Telephone call made Left second voice mail requesting call back from Staff #2.
08/04/2022	Contact - Telephone call received Follow-up interview with Staff #1.
08/04/2022	Contact – Document Received Instead of status checks that I requested, M. Dyki submitted an "Access History" list of Resident B's room from 6/1/2022 to 6/29/2022.
08/04/2022	Contact - Telephone call made Follow-up interview with Mr. Dyki.
08/04/2022	Contact - Telephone call made Interviewed Staff #3
08/05/2022	Contact – Telephone call received Heather Richter of the Oakland Co. Sheriff Records Dept. called to report no findings of 6/20/2022 pertaining to Resident B, this address or nearby church address. She did several different searches in various ways and was unable to find any record or dispatch information on this incident.
08/05/2022	Contact – Document Received Email from Heather Richter of the Oakland Co. Sheriff Records Dept. to confirm no reports of police responding to incident pertaining to Resident B on 6/20/2022.
08/05/2022	Contact – Telephone call made Called Oakland Co Fire Dept. spoke with Holly. Holly confirmed the FD responded and she will check with fire chief whether documentation about the incident may be provided.
08/05/2022	Contact – Document Received

	Instead of status checks that I requested, M. Dyki re-submitted the "Access History" list of key fob times that individuals entered Resident B's room from 6/1/2022 to 6/29/2022, adding in the job description of each individual that entered the room.
08/05/2022	Contact – Document Sent Email to M. Dyki, re-stating that room access times do not confirm Resident B was even in the room. They only confirm that someone entered the room. I again requested that he provide the 2-hour status checks, whereas staff see resident and then confirm their observation with a push of the "Rounds" button in the resident's room.
08/05/2022	Contact – Telephone Call Received Holly of the Oakland Twp. fire dept. called confirming FD was the first responder, but fire chief requires I contact city hall for a FOIA request of the incident.
08/05/2022	Contact – Document Sent As informed by the receptionist at Oakland Twp. City Hall, I emailed a formal request to Roxanne Thatcher and Jamie Moore for the fire dept. record, because no one was available to take my call.
08/10/2022	Contact – Document Received Oakland Twp. Fire Incident Report and Oakland Twp. Fire Dept. Patient Care Record from Roxanne Thatcher, FOIA Coordinator Charter Township of Oakland
08/11/2022	Contact – Document Sent Area manager Andrea Moore sent via email a request to Mike Dyki for the weekly report of in-room button two-hour status checks.
08/16/2022	Contact – Document Received ALD submitted via email the two hour status check "Rounds Resident Report" and the "Resident Event Report" for Resident B from 6/13-6/20/2022. The Rounds Report revealed no rounds button was pressed by the staff for Resident B's status that week.
08/17/2022	Contact – Document Sent Email to M. Dyki requesting list of residents in the assisted living area, and a list of residents in the memory care area. If any of the residents are new admissions since June, please cross them out.
08/17/2022	Contact – Telephone Call Made

	Called facility M. Dyki not available. Left message with receptionist Renee asking M. Dyki respond to my email.
08/17/2022	Contact – Document Received ALD submitted Resident Census via email.
08/17/2022	Contact – Document Sent Email to M. Dyki requesting Rounds Resident Report for four specific residents for July 1-7, 2022, to be submitted by close of business on 8/18/2022.
08/19/2022	Contact – Document Received M. Dyki provided documentation of resident room doors being opened, not actual "rounds" buttons being pushed by staff to confirm two-hour checks.
05/04/2023	Exit Conference – Conducted with authorized representative M. Dyki via telephone.

ALLEGATION:

On 6/20/2022, Staff #1 unlocked the door to allow Resident B to exit facility and roam outside unsupervised for more than an hour. A bystander found him in a pool of blood on the ground at a nearby church and called for help. Resident B suffered injuries of a broken wrist, stitches in his hand and forehead, and a brain bleed.

INVESTIGATION:

On 6/27/2022, the allegations were received by the Department of Licensing and Regulatory Affairs via the online intake unit from adult protective services (APS), as the allegations were initially reported to APS. The reporting source (RS) of the complaint was identified. As APS had already received the allegations, I did not make a referral.

On 6/28/2022, I reviewed the incident report completed by the facility that was submitted to the Dept. of Licensing and Regulatory Affairs (LARA) licensing staff Aaron Clum. According to the incident report, on 6/20/2022 at 5:55 pm Resident B was observed by care staff (no name specified) walking toward concierge desk. Concierge staff #1 opened the door for Resident B, the care staff (again, no name specified) was not notified. At approx. 7:45 pm Oakland Twp. fire dept. and Oakland Co. sheriff dept. entered the building and asked if Resident B was a resident of Blossom Springs, as he was found to have fallen in the adjacent parking lot. Per EMS Resident B had a laceration to his face and thumb and was complaining of left wrist pain. He was transferred to the hospital. The resident's authorized representative was notified at 8:01 pm, his physician notified at 9 pm, and LARA was

notified via assigned licensing staff Aaron Clum on 6/22/2022 at 4:30 pm. According to the incident report, the hospital would not disclose injuries, but Resident B's authorized representative reportedly told the home that he had a fractured left wrist, stitches to his thumb and above his eye, and a possible "bleed on the brain". For corrective measures to prevent recurrence it is written, "All staff including the concierge have been retrained as to residents leaving the community. Residents will not be allowed out of the community unless they are with a staff or family member. [Staff #1] (Concierge) was terminated following investigation."

On 6/28/2022, Aaron Clum emailed that he was unsure whether the home notified him of the incident within the required 24 hours of an elopement, as there may have been an email from the facility prior to the incident report submission on 6/22/2022.

On 6/29/2022, I interviewed Mike Dyki, licensee authorized representative and administrator by telephone. Mr. Dyki said Resident B resided in the "assisted living" area of the facility for approximately one year. He would go outside for activities but not by himself unsupervised. Mr. Dyki said at approximately 5 pm on 6/20/22, staff asked Resident B if he wanted dinner that night. Resident B replied "No" and he went back to his room. Mr. Dyki said that Staff #1 then let Resident B out of the facility at 6:03 pm and he fell "around 7:30" pm. Mr. Dyki said he was called "around 7:45" pm and said that was within the facility's two-hour status check window, whereas staff check the welfare of each resident every two hours. Mr. Dyki said Staff #1 has been terminated.

Upon request, I received various documents and a video from Mr. Dyki on 6/29, 6/30, 7/1 and 7/7/2022. The video is date/time stamped 20220620 180224 [06/20/2022 6:02 pm (24 seconds)]. The video transpires for approximately 30 seconds but the date/time stamp never changes.

Review of the video revealed the backside of Resident B using his walker while walking away from the camera toward the main entrance/exit door. Staff #1 then appears on screen, coming out of an office walking toward the seat of the concierge desk, which is between the office and the entrance/exit door. Staff #1 observes Resident B at the main entrance/exit door. Staff #1 then walks around her desk and towards the main entrance/exit door while looking at a bracelet-type device on her right wrist. Staff #1 uses the wrist device raising it to the right side of the door which unlocks/opens the door allowing Resident B to exit. Although there is no audio, there does not appear to be any communication between Staff #1 and Resident B. Staff #1 turns away from the door while grabbing a nearby cart and moving it around a wall. Staff #1 then turns away from the area and walks back around the concierge desk and re-enters the office when the video ends.

A circuit court document dated 5/10/2021, submitted by Mr. Dyki, ordered a family member to be the plenary guardian of Resident B, person and property. The document read, "…the Court finding that the Ward is totally incapacitated as adjudicated by Order of this Court pursuant to the hearing on May 7, 2021, and the

court finding that is necessary for a plenary guardian to be appointed for the Ward's person and property…"

On 8/1/2022, I interviewed the reporting source (RS) of this complaint by telephone. The RS said Resident B was placed into the facility on 9/16/2021 by his plenary guardian, having been told that the entire facility was secured. The RS said Resident B had a history of strokes in 2017 and 2018, resulting in left side stroke-related deficits causing an unsteady gait and the need for assistance with showering and medications. RS said Resident B had a third stroke in February 2022, while residing at Blossom Springs. The RS said Resident B's guardian was told the facility was secure and did not allow any residents outside without family or a caregiver. However, on 6/20/2022 Staff #1 opened the door and allowed Resident B to exit the facility. The RS said the guardian was not notified that Resident B left the facility unsupervised, until after the resident was found injured on the ground and taken to the hospital.

The RS reported Resident B had been left outdoors for hours and no one was looking for him. Resident B wandered approximately 200 yards to the church next door, where a bystander found him in a pool of blood on the pavement at the bottom of the church steps and called an ambulance. Resident B had fractured his left arm, had stitches put in his right palm and above his left eye. He had a brain bleed and multiple lacerations on his arm and legs related to crawling in the parking lot. The emergency room physician recommended surgery to the brain bleed, but another physician did not agree due to his age (90 years old) and other medical conditions.

On 8/2/2022, I went to the facility for interviews, observations, and to review documents. Some previously submitted documents from Mr. Dyki were illegible as they only scanned the middle portion of the pages. The right and left hand sides of the pages were blank. At the facility, I could review the pages in entirety.

Review of the facility's 12/17/2021 assessment of Resident B indicates he had dementia diagnosis fluctuation in cognition possible; has mild to moderate disorientation or difficulty recalling/retaining information; Needs cueing; Moderate dementia with significant short-term memory and possibly long-term memory loss. The assessment also reported Resident B had an unsteady gait and a history of falls within the past three months. As an intervention it read, "Is at risk for falls due to unsteady gait secondary to dementia diagnosis and failure to use cane at all times. Remind to use cane if seen without it." The assessment also reads, "[Resident B] enjoys going outside" and "[Resident B] is able to move about the community without assistance" but does not specify whether he requires supervision outside the facility. At the time of the assessment, Resident B used a cane for ambulation, and if he was observed unsteady with his cane staff were to assist him to where he was going.

On 8/2/2022, I interviewed Mr. Dyki and the facility's Assisted Living Director (ALD) together at the facility and reviewed Resident B's service plan. Mr. Dyki and ALD confirmed that Resident B's service plan dated 12/28/2021 was the most recent plan

because it included “Target Date” of 6/28/2022 for the various services provided. This 12/28/2021 service plan included, “Please escort [Resident B] to meals. [Resident B] may not remember where the dining room is located…[Resident B] will be supported to make appropriate decisions about his care and environment…Dementia Diagnosis fluctuation in cognition possible Has mild to moderate disorientation or difficulty recalling/retaining information. Needs cueing. Moderate dementia with significant short-term and possibly long-term memory loss…[Resident B] is able to move about the community with the use of his walker…AMBULATION [Resident B] walks with a walker…Has history of falls which puts the resident at risk if he ambulates without walker…Ensure [Resident B] uses his walker any time he ambulates Escort as needed to/from activities and or dining room MOBILITY: Mobile with assistive device: two-wheeled walker standby assistance with walker for ambulation if [Resident B] feels weak …Is at risk for falls due to unsteady gait secondary to dementia diagnosis and failure to use walker at all times.”

Resident B’s service plan did not address the level of supervision he requires outside the facility. It also did not address staff conducting status checks of Resident B on a daily basis. Mr. Dyki said Resident B could go outside the facility unsupervised. Mr. Dyki said Staff #1 was terminated because she did not notify other staff of Resident B leaving the building. Mr. Dyki and the ALD explained that it is expected the concierge notify care staff every time any resident leaves the building, so the staff can provide their medications if needed, and know whether the resident will miss a meal.

Both Mr. Dyki and ALD stated that status checks of all residents are conducted by staff at least every two hours. ALD further explained that the staff are assigned to specific residents according to the “Floor Schedule”. The staff are expected to check on their assigned residents every two hours and press a “Rounds” button located on the wall in each resident’s room which then documents that that they observed the resident. ALD checked the floor schedule for 6/20/2022 and said Staff #2 was responsible for Resident B on second shift 3 pm to 11:30 pm. ALD then reviewed the company’s PointClickCare software program and said there was no “Rounds” button documentation for any staff having observed Resident B on 6/20/2022.

ALD presented a form where staff are expected to hand write “comments” about each resident on each shift. For 6/20/2022, the 3rd shift from the previous night recorded Resident B as “up and wandering the halls multiple times”. There were no other “comments” documented for Resident B by first and second shift staff on 6/20/2022.

I reviewed handwritten statements that were documented after the 6/20/2022 incident. Staff #2, who was assigned to Resident B, wrote “[Resident B] was last seen by me when I was walking out of the dining room walking towards the care station one in AL. I saw him at the front door with only [Staff #1] and talking with her.

I am not sure because I was walking by quickly, but I thought the door opened." No time of observation was documented. ALD said Staff #2 is no longer employed. I attempted to reach Staff #2 and left voice mails on 8/3 and 8/4/2022, but she did not return my calls.

Staff #3 was the medication technician for the area, where Resident B resided on 6/20/2022. Staff #3 wrote, "[Resident B] was last seen by me around dinner time 5pm and 6pm. I pulled up his pants by care station one in assisted living and he headed back to his apartment and I continued passing medications."

On 8/4/2022, I interviewed Staff #3 by telephone and read the above written statement to her. Staff #3 said she does not remember writing the two different times, 5 pm and 6pm, and she did not know why she did that. Staff #3 recalled asking Resident B if he was going to dinner at that time and he replied he was not. Staff #3 said dinner is usually served from 5 pm to 6 pm. Staff #3 said she passes medications for residents who need them administered before dinner beginning at 4 pm until 5:30pm and according to the written note she was still passing the medications. After discussing these events, Staff #3 said she believes it was 5pm to 5:30pm that she last saw Resident B on 6/20/2022.

Staff #4 also worked in Resident B's area beginning at 4 pm on 6/20/2022. Staff #4's written statement read, "The last time I saw [Resident B] was in his room in his chair. It was around 4:45-5:15 pm probably. I asked if he was hungry/wanted to come down to the dining room to eat. He said no, he wasn't hungry, so I left and continued to bring residents to the dining room".

On 8/2/2022, I interviewed Staff #5 at the facility. Staff #5 said she has worked at the facility since it opened in September 2020, and she is a full-time day shift concierge. Staff #5 said the entire facility, both assisted living area and memory care area, is locked down and only staff carry key fobs to unlock the doors. No residents can go outside the facility without staff or family members. Staff #5 said Mike Dyki and Staff #6 taught her that no resident is to leave unattended. Staff #5 said part of her job is to let people in and out the door and to keep an eye on a monitor of video cameras throughout the facility to see if any residents are going to doors seeking to exit. Staff #5 said if she observes this happening, she notifies staff who redirect and distract the resident away from the door. Staff #5 said Resident B would go out with his grandsons but never alone.

Staff #5 said Staff #1 was a part-time concierge, and that Staff #1 shadowed Staff # 5 for a period of time to learn the job. Initially, Staff #5 said she did not recall having told Staff #1 that no residents are to leave the facility unsupervised. Staff #5 said, I'm not a teacher. Later in the interview, Staff #5 said, "I'm sure I said this is a secure community. The only one that can go out is families. Residents can't go out without [staff/family]. Every door is locked. No one gets out without staff." Staff #5 then corrected herself and said Resident C drives and she is the only resident that can be allowed to go outside unsupervised by staff or a family member. Staff #5 later

added some other residents come in for rehab or respite and “they are of sound mind”, so they could leave independently. Staff #5 gave an example of a resident that resided for two months for physical assistance after shoulder surgery. Staff #5 said, “I let her go out and sit on the bench. I could see her.” When asked if Staff #5 reviews resident service plans or has access to them, Staff #5 said no.

On 8/2/2022, I interviewed medication technician/caregiver Staff #7 at the facility. Staff #7 said “[Resident B] can’t go outside without a family member (because) He was a fall risk. He was bad on his feet. He would fall in his room and not tell staff until the next day”. Staff #7 recalled two occasions when she observed Resident B asking staff to open the door for him so he could leave. Once was at 7-7:30 am when he had his jacket and asked staff, “Can someone open the door?” Staff #7 said other staff redirected him by saying it’s too early to leave, let’s get something to eat. Staff #7 said this happened with Resident B “Every now and then. Not every day”. Staff #7 explained another occasion approximately 9:45 pm when Resident B was sitting in a chair with his walker asking, “Can someone open this door?” Staff #7 said her usual response was something like, “We don’t have permission” or “The door is broke”. Staff #7 named Resident C, Resident D, and Resident E, as three residents who are capable of going outside independently without supervision. Staff #7 explained that Resident C drives, Resident D will sit on a bench outside, and Resident E takes outside walks, although she usually requests staff to go with her “because she likes a companion to talk to”. Staff #7 also explained the facility’s monitoring system of doing safety status checks on all residents every two hours and pressing the “Rounds” button in each resident’s room. Staff #7 then explained that staff are not reliable in doing this, including herself.

On 8/1 and 8/4/2022, I conducted telephone interviews with Staff #1. Staff #1 reported having worked at the facility for 8 months before this 6/20/2022 incident. Staff #1 affirmed that upon hire, she shadowed and was trained by concierge Staff #5 and said part of her concierge job entailed allowing people in and out the main entrance/exit door. Staff #1 said when residents would leave the home, it was expected that she would write down on a list the time the resident left, who they left with, and the time they returned. Staff #1 said she only notified staff of the resident leaving if the resident was expected to be gone a full day or for the weekend. At that time, she would contact the nurse for any medications that may need to go with the resident. Staff #1 said she would not write down or notify the staff if the resident was just going outside to sit on the bench or walk around the grounds. Staff #1 said she was never told which specific assisted living residents could go outside unsupervised. Staff #1 said she knew the memory care residents could not go outside independently, but there were some assisted living residents that could go outside alone such as Residents C, D, and E. Staff #1 said she was not trained on resident service plans, nor was she told to review resident service plans to know the level of supervision each resident required. Staff #1 said she did not recall opening the door to allow Resident B to exit on 6/20/2022, and she also did not recall any staff near her at the time to see him.

On 8/3/2022, I reviewed special investigation report (SIR)2022A0585042 of Blossom Springs completed by licensing co-worker Brender Howard. The report documented a violation of R325.1921(1)(b). According to the report Resident A was known to be exit seeking and her service plan did not reflect her increasing need for supervision. Specifically, it lacked the frequency of safety checks. Due to this insufficiently developed plan, on 3/28/2022 Resident A was last observed by staff at midnight and at approximately 4 am was found outside in the courtyard yelling. Consequently, Resident A suffered hypothermia.

On 8/3/2022, I reviewed Mr. Dyki's 6/13/2022 corrective action plan to SIR20220585042 that was submitted to the department. It read, "The community and its staff will ensure all residents are 'protected' while under the care of the community. Each resident service plan will be followed according to needs, if that includes continuous supervision then the community and staff will ensure whereabouts every 2 hours. The ED [executive director] and Nurse will be responsible for ensuring compliance is met. The correction for the violation is immediate and on-going. The ED and Nurse will monitor the check in buttons inside apartments by running a weekly report on status of checks. The community and its staff will ensure all resident whereabouts are known every '2' hours. The entire staff is responsible for ensuring compliance is met. The correction for the violation is immediate and ongoing. The ED and Nurse will ensure residents are safe to travel through the community and if they are in the outside courtyards we will have a staff member present at all times."

On 8/4/2022, in a follow-up telephone call, Mr. Dyki said "ED" meant executive director and that it refers to himself, as the administrator of the facility.

While at the facility on 8/2/2022, the ALD said to Mr. Dyki and me, that she was unable to locate any two-hour status checks of Resident B for 6/20/2022.

On 8/3, 8/4, and 8/5/2022, I requested Mr. Dyki submit the two-hour status checks for Resident B from 6/13 to 6/20/2022, that Mr. Dyki would typically review, as part of his corrective action plan to SIR2022A0585042. There was no PointClickCare software program "Rounds" button documentation submitted. Instead, Mr. Dyki submitted an "Access History" document that lists the key fobs that opened the door to Resident B's room. This includes Staff #8 housekeeping and Staff # 9 laundry staff key fobs opening his door.

According to the "Access History" document, on 6/20/2022, caregiver Staff # 2 opened the door at 17:10:55 (5:10pm) and caregiver Staff #4 opened his door at 17:14:26 (5:14pm). It could not be determined whether Resident B was in his room at the times staff entered his room, because documentation revealed Resident B opened his own door with his own key fob at 17:29 pm (5:29 pm).

On 8/11/2022, licensing area manager Andrea Moore sent an email to Mr. Dyki requesting the weekly report of the in-room "Rounds" button status checks.

On 8/16/2022, the ALD submitted via email the two-hour status check “Rounds Resident Report” for Resident B from 6/13 to 6/20/2022. It revealed no “Rounds” button was pressed by the staff for confirming his status that week. The ALD also submitted the “Resident Event Report” for 6/19 to 6/20/2022. It revealed only one entry of 6/19/2022 at 4:22 am that Resident B pressed his call-alert pendant three times and staff responded in seven minutes.

On 8/10/2022 I received the Oakland Twp. Fire Incident Report and Oakland Twp. Fire Dept. Patient Care Record from Roxanne Thatcher, FOIA Coordinator Charter Township of Oakland.

According to the Oakland Twp. Fire Incident Report, the “Alarm Date and Time” was 06/20/2022 at 19:23:34 (7:23 pm) and the “Arrival Date and Time” was 06/20/2022 at 19:31:13 (7:31 pm) with a “Response Time” recorded as 7:39 (seven minutes and 39 seconds).

Oakland Twp. Fire Dept. Patient Care Record read, “ATF 90 year old male lying on his back near some concrete steps at the church with dried blood on his face and hands. There is a dried puddle of blood approximately 10 inches in diameter near the patient. It appears he crawled over approximately 8 feet. A bystander found the patient in this condition and called ems. IPS reveals a couple of 1" lacerations to the left side of the patients face along with a laceration to his right palm and and abrasion to his left wrist. Patient states he lives on torrey lane in Flint Michigan. There is a walker nearby with a room number on it and the patient has a key fob that looks like it is from Blossom Springs. Fire sent a unit to check, and he is a resident. Fire was able to obtain patient information from Blossom Springs. Patient has good movement in all his extremities, and he states he has neuropathy. Fire obtained vitals. Patient denies any neck or back pain while lying and he was placed in a c collar. Patient has no pain in his abdomen upon palpation. Patient was log rolled onto his back and fire checked for any deformity or tenderness which is negative. Patient arms and legs were palpated with no notable deformities. Patient wounds were bandaged with 4 x 4's and roller gauze. Patient was loaded for transport. Patient was monitored through out the transport. Upon arrival at the ER patient was transferred to the hospital bed via the stretcher sheet, a verbal report given to the nurse and care was turned over to the ER staff.”

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.**

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. **(23) "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 B had documented moderate dementia with significant short-term and possibly long-term memory loss. A court deemed him totally incapacitated requiring a plenary guardian of person and property. Resident B also suffered strokes resulting in left side deficits and an unsteady gait requiring him to utilize a walker. Given his cognitive and physical ability, it would be reasonable that Resident B would require supervision whenever leaving the facility. However, Resident B's service plan did not reflect his need for supervision outside the facility, nor did it address the status checks while in the building. In addition, Staff #1 had the responsibility of opening and closing the main door to residents, guests, and visitors but she was not adequately trained to know who could leave the facility unsupervised nor which situations of exit to report to staff. Staff #1 said she only notified staff of a resident leaving if the resident was expected to be gone a full day or for the weekend. As a result, Staff #1 opened the door for Resident B to leave the facility unsupervised on 6/20/2022 at 6:03 pm and she did not notify staff, which resulted in Resident B's injury and being found by a bystander, who then reported to the fire department at 7:23 pm. Written statements after the incident and interview with staff indicate Resident B was last observed by staff between 5pm and 5:30 pm on 6/20/2022. There is no evidence to confirm that

	Resident B received status checks conducted every two hours by staff during the 3pm to 11pm shift of 6/20/2022. Therefore, the owner, operator, and governing body did not assure an organized program of protection and supervision for Resident B.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED [Ref: Special Investigation Report (SIR) 2022A0585042]**

ALLEGATION:

Resident B was not bathed twice weekly in accordance with his service plan.

INVESTIGATION:

During the 8/1/2022 telephone interview, the RS said Resident B was visited daily by family and Resident B would often look unkempt with crusty layers of skin behind his ears and eyes. Resident B was supposed to receive assistance with showers from staff two days a week, but it did not appear to be given. Resident B's family hired a personal caregiver, who reportedly told RS that she observed staff saying showers were given but they were not. Resident B did not return to the facility after the 6/20/2022 incident.

On 8/2/2022, I observed residents in various areas of the assisted living where Resident B resided. The residents appeared clean with no notable odors and wearing clean clothes. Staff #7 said Resident B was scheduled to have showers on Tuesdays and Saturdays, which is consistent with his service plan. ALD was only able to locate Resident B's shower documentation for June 2022, explaining that it is purged every month. Staff documentation indicates Resident B received assistance from staff with showers on Sat. 6/4; Tues. 6/7, Tues. 6/14 and Sat. 6/18/2022. There was no documentation for Sat. 6/11/2022, as would be expected. Staff #7 said if Resident B had refused a shower on Sat. 6/11/2022, staff would have written "refused" for that day and not offer another shower until the following Tuesday 6/14/2022. Staff #7 said Resident B would refuse showers from other staff, but he would always accept assistance from her.

On 8/2/2022, I interviewed Resident F and Resident F's family member, Relative F. Resident F indicated satisfaction with facility services he receives. Relative F said she visits the home daily and observes Resident F and other residents appearing clean and wearing clean clothes. Relative F said Resident F received showers twice weekly when he was able, and then sponge baths are provided whenever bandages prevented showering. Relative F stated she was pleased with services that she sees provided in the facility.

APPLICABLE RULE	
R 325.1933	**Personal care of residents.**
	(2) A home shall afford a resident the opportunity and instructions when necessary for daily bathing, oral and personal hygiene, daily shaving, and hand washing before meals. A home shall ensure that a resident bathes at least weekly and more often if necessary.
ANALYSIS:	Resident B's shower documentation for Sat. 6/11/2022 could not be located, therefore, it cannot be determined whether Resident B received or refused a shower that day. However, Resident B's remaining shower documentation for June was present and indicated the showers were given. Resident B no longer resides in the facility. Observation of other residents and interview with another resident's family member indicate showers are provided at least weekly and more often if necessary.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

The facility's incident report dated 6/20/2022 indicated the incident occurred at 6:02 pm when Resident B left the facility. At approximately 7:45 pm Oakland Twp. Fire Department entered the building, asking if Resident B was one of the facility's residents, and that he had fallen in the adjacent parking lot. EMS transported him to the hospital.

The incident report indicates Resident B's physician was not immediately notified but instead notified at 9 pm on 6/20/2022.

The incident report indicates Resident B's authorized representative, Relative B1, was notified at 8:01 pm on 6/20/2022. However, on 8/17/2022, I interviewed Resident B's authorized representative, Relative B1, by telephone. Relative B1 said the facility did not call and notify him of the incident. The hospital texted Relative B1 that he was being admitted and needed to do a remote check-in. Relative B1 then called the facility as to why Resident B was being admitted into the hospital. Relative B1 was told Resident B fell in the parking lot, and they were checking video monitoring cameras to see how he got out there. Relative B1 said it was a couple days later that the facility informed him of what occurred.

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, accidents, elopement.**
	(3) The home shall report an incident/accident to the department within 48 hours of the occurrence. The incident or accident shall be immediately reported verbally or in writing to the resident's authorized representative, if any, and the resident's physician.
ANALYSIS:	The facility did not immediately notify Resident B's physician of the incident when Resident B was sent to the hospital at 7:45 pm on 6/20/2022. According to the incident report, his physician was notified an hour later at 9 pm. In addition, the incident report indicates Relative B1 was notified of the incident at 8 pm on 6/20/2022. However, Relative B1 said it was the hospital, not the facility, that notified him of Resident B's admittance into the hospital. Relative B1 then called the facility to find out what happened to cause this hospitalization.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

Review of Staff #1's training curriculum provided by Mr. Dyki, revealed Staff #1 had no training in resident service plans. It also revealed no training about which assisted living residents may or may not leave the facility unsupervised. On 8/2/2022, Mr. Dyki initially said Staff #1 knew Resident B was not to leave the facility alone. Later that same day, Mr. Dyki said Resident B could leave the facility, but Staff #1 was terminated because she did not notify staff that he left the building, and she was required to do so.

On 8/2/2022, I interviewed Staff #6 at the facility. Staff #6 explained that she provided Staff #1 with concierge training and discussed the training with her. Staff #6 said she did not know if there was any competency evaluation or acknowledgement of the training. Staff #6 then presented the "First Impressions Exceeding Expectations" training packet that Staff #6 said she developed for the concierge staff. It included information about first impressions in person and on the telephone, phone etiquette, and how the community presents itself. Staff #6 then confirmed there was no competency evaluation of the training.

In reference to the concierge's responsibility of residents exiting the facility, Staff #6 pointed to two specific questions on the page that begins "IN PERSON Imagine you are walking into your community for the first time, what impression would you have upon entry? Does the community look and smell clean…Do the residents look happy and well taken care of? Are all residents in the building? Have you notified

staff if they have left? How about the staff, do they look happy to be at work? Is this a place you would want to bring your loved one?" Staff #6 pointed to the two questions of: Are all residents in the building? Have you notified staff if they have left? indicating this was the training that Staff #1 was supposed to know to notify staff every time any resident leaves the facility, even if to just sit outside on a bench or to walk around the sidewalk. Staff #6 confirmed that other than the two written questions, there was no further instruction as to the concierge's duties related to the residents entering and exiting the facility and no competency evaluation.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(6) The home shall establish and implement a staff training program based on the home's program statement, the residents service plans, and the needs of employees, such as any of the following: **(a) Reporting requirements and documentation.** **(b) First aid and/or medication, if any.** **(c) Personal care.** **(d) Resident rights and responsibilities.** **(e) Safety and fire prevention.** **(f) Containment of infectious disease and standard precautions.** **(g) Medication administration, if applicable.**
ANALYSIS:	Staff #1 worked at the facility for eight months. As the concierge, Staff #1 had the responsibility to unlock and open the main entrance/exit door and allow residents to leave the facility unsupervised. The facility provided no training to Staff #1 on resident service plans nor any specific knowledge of which residents have the cognitive and physical ability to leave the facility unsupervised. Although Staff #6's *First Impressions* training packet included two questions of: Are all residents in the building? Have you notified staff if they have left? There were no instructions/procedures for the concierge about these questions. As a consequence, Staff #1 allowed Resident B to leave the facility unsupervised resulting in his injuries.
CONCLUSION:	**VIOLATION ESTABLISHED**

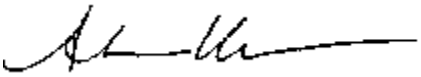
APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(7) The home's administrator or its designees are responsible for evaluating employee competencies.

ANALYSIS:	There was no evidence of competency evaluation for Staff #1's ability to be the concierge for the facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 05/04/2023, I reviewed the above findings with authorized representative Michael Dyki by telephone.

III. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, it is recommended that the status of the license remain unchanged.



08/08/2022

_____

Andrea Krausmann Date
Licensing Staff

Approved By:

05/04/2023

_____

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