GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

February 29, 2024

Mary North
Brookdale Grand Blanc AL
5080 Baldwin Road
Holly, MI 48442

RE: License #: AH250236939
Investigation #: 2024A0585014
Brookdale Grand Blanc AL

Dear Ms. North:

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 (517) 284-9730.

Sincerely,

Brender L. Howard

Brender Howard, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street, P.O. Box 30664
Lansing, MI 48909
(313) 268-1788
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH250236939
Investigation #:	2024A0585014
Complaint Receipt Date:	01/16/2024
Investigation Initiation Date:	01/17/2024
Report Due Date:	03/15/2024
Licensee Name:	Brookdale Senior Living Communities, Inc.
Licensee Address:	Suite 2300 6737 West Washington St. Milwaukee, WI 53214
Licensee Telephone #:	(414) 918-5000
Administrator:	Heather Vahlbusch
Authorized Representative/	Mary North
Name of Facility:	Brookdale Grand Blanc AL
Facility Address:	5080 Baldwin Road Holly, MI 48442
Facility Telephone #:	(810) 953-7111
Original Issuance Date:	10/01/1998
License Status:	REGULAR
Effective Date:	05/07/2023
Expiration Date:	05/06/2024
Capacity:	78
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident A eloped from the facility and was struck by car.	Yes
Additional Findings	No

III. METHODOLOGY

01/16/2024	Special Investigation Intake 2024A0585014
01/17/2024	Special Investigation Initiated - Letter Emailed referral to Adult Protective Services (APS).
01/18/2024	Contact - Telephone call made. Contacted staff regarding the incident.
01/25/2024	Inspection Completed On-site Completed with observation, interview, and record review.
02/01/2024	Contact – Document sent. Emailed administrator for additional information.
02/02/2024	Contact – Document received. Administrator emailed requested additional information.
03/01/2024	Exit Conference. Conducted via email to authorized representative Mary North.

ALLEGATION:

Resident A eloped from the facility and was struck by car.

INVESTIGATION:

On 01/16/2024 the Bureau of Community and Health Systems (BCHS) received an anonymous complaint that in part read, “On 01/08/2024, resident eloped from the home and was struck by a car and passed away.”

On 01/17/2024, a referral was sent to Adult Protective Services.

On 1/25/2024, I interviewed Relative A1 by telephone. Relative A1 stated that they got the call that night regarding an incident, and told them that they were trying to revive Resident A. Relative A1 stated that she thought the facility was locked at night and she don't know how that happened. She said that the staff didn't know that Resident A had left the facility.

On 01/25/2024, an onsite was completed at the facility. The administrator Heather Vahlbusch was not there at that time. I interviewed Employee #1 at the facility. Employee #1 stated, Resident A left out the front door and no one knew he had left. She stated that a staff member is at the front door during the day. She stated that residents on that side can come and go whenever they get ready to. She stated that there is no office staff at night. Employee #1 stated staff do two-hour checks and Resident A did not have a history of eloping. She said that the 911 call went out at 8:10 p.m. from the scene of the accident. She said Resident A was last seen by staff 10 to 15 minutes before being notified of the incident. Employee #1 explained that there were six care staff in the facility on that night. Employee #1 stated that there are no alarms on the door and there are no cameras. Employee #1 stated that Resident A had early dementia but was independent of all ADLs. She explained that all residents are supposed to sign in and out, but Resident A did not sign out that day.

On 1/30/2024, I interviewed Employee #2 at the facility. Employee #2 stated that Resident A never displayed elopement behaviors before. She said there were no change in condition. She said Resident A was very social and independent in ADL.

On 1/30/2024, I interviewed Employee #3 at the facility. Employee #3 said that they never thought Resident A would do anything like that. She said that there is a receptionist at the front desk until 5 p.m. She said the doors are not locked. She said that they do evaluation of residents to see if they are showing signs of elopement/exit seeking. Employee #1 stated that Resident A appeared to be his normal self-interacting with other residents.

I interviewed Employee #4 by telephone. Employee #4 stated that Resident A has mild dementia, but he can communicate his needs. She stated that she was shocked about the incident. She stated that residents are supposed to sign in and out whenever they leave the facility and come back to the facility.

I interviewed Employee #5 who stated that she wasn't at work when the incident happened. She stated that this has never happened before because Resident A did not like cold weather, and she was shocked that he went out. She said that the census was 20 residents and there were six staff to care for them. Employee #1 stated that residents does not always sign in and out.

I interviewed Employee #6 by telephone. Employee #6 stated that Resident A had memory issues and he had declined a lot. Employee #6 said that he had trouble finding the elevator and would often get loss in the building. She said residents are

supposed to sign in and out but don't always do it. She said that Resident A does not go outside by himself especially now because he doesn't like cold weather. She said that there is no receptionist at night, and she don't know why the alarm was not on the door that night. She explained that Resident A was not an elopement risk. She said that Resident A was about 200 feet down the road, and he had his walker with him.

Service plan for Resident A read, "Resident is independent with mobility, he uses a can or walker as a mobility aid. Resident is able to be outside the community unescorted. Resident is oriented to person, place and time. Resident can communicate needs and preferences (verbally and non-verbally)".

Documents emailed to the department read, "…. spoke to police on the scene who stated they received a 911 call at 8:10 PM. Police stated it appears the resident was walking eastbound on Baldwin Rd and was struck from behind by a car that was traveling eastbound on Baldwin Rd. EMS performed CPR at the scene but were unsuccessful and the resident was pronounced dead. ….. notified the resident's PCP and ED notified the family. Staff stated the last time the resident was seen in the community was around 7:50 PM leaving another resident's room. Resident has no history of attempted elopement. Resident was his own responsible party and cognitive to make his own medical and financial decisions".

On 2/1/2024, I emailed Ms. Vahlbusch for additional information. Ms.Vanhlbusch emailed, " Community assessments are completed upon move in, initial assessment, change of condition, and every 6 months. PCP oversight in community weekly. We have someone in the front office area on average 9 am to 5 pm Monday through Friday. Our exterior doors at the end of each hallway and to the courtyard are alarmed daily, the front door gets alarmed at dust. Residents should sign out and sign in each time they leave or return to the building as well as indicate contact information during their absence from the community. Associates may provide assistance with this as needed. When [Employee #1] and myself had spoken to the Grand Blanc Police Officer they specified that they were needing to contact family first."

On 2/8/2024, I contacted Ms. Vahlbusch by telephone for clarification regarding the alarm at the front door. She stated that the alarm is turned on at dust between evening and midnight shift.

A review of the sign in/sign out log for 01/08/2024, it did not show Resident A signing in or signing out.

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.**
	(p)"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.
ANALYSIS:	The service plan for Resident A indicated that he was able to leave the facility without supervision. Staff had noted that Resident A had increased instances of confusion. His service plan was not adjusted to reflect this and provide increased supervision or assistance. On 01/08/2024, staff were unaware that Resident A had left the building after dusk, as the door alarm did not alert staff. The facility has a sign out sheet that residents are supposed to sign when going in and out of the facility, but residents does not always sign out. Therefore, the facility did not assure the safety of Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

02/29/2024

Brender Howard — Date
Licensing Staff

Approved By:

02/29/2024

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