RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

May 23, 2017

Nancy Harns
Williamston Compassionate Care, LLC
3800 Vanneter Rd
Williamston, MI 48895

RE: License #: AM330380484
Investigation #: **2017A0777005**
Williamston Compassionate Care, LLC

Dear Ms. Harns:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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) 284-9727.

Sincerely,

Stephanie Gonzalez, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 243-6063

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM330380484
Investigation #:	2017A0777005
Complaint Receipt Date:	12/27/2016
Investigation Initiation Date:	12/28/2016
Report Due Date:	02/25/2017
Licensee Name:	Williamston Compassionate Care, LLC
Licensee Address:	3800 Vanneter Rd Williamston, MI 48895
Licensee Telephone #:	(517) 204-2480
Administrator:	Nancy Harns
Licensee Designee:	Nancy Harns
Name of Facility:	Williamston Compassionate Care, LLC
Facility Address:	3800 Vanneter Rd Williamston, MI 48895
Facility Telephone #:	(517) 204-2480
Original Issuance Date:	03/25/2016
License Status:	REGULAR
Effective Date:	09/25/2016
Expiration Date:	09/24/2018
Capacity:	12

Program Type:	AGED ALZHEIMERS

ALLEGATION(S)

	Violation Established?
Resident A has been found wandering the neighborhood on several occasions by the local police department.	Yes
Additional Findings	Yes

II. METHODOLOGY

12/27/2016	Special Investigation Intake 2017A0777005
12/28/2016	Special Investigation Initiated - Telephone Spoke to Complainant
01/12/2017	Contact - Document Sent to APS Specialist Jimmie Harris
01/20/2017	Inspection Completed On-site Interview with Resident A and direct care staff members Shelly Stuber, Rhonda Seno, Rita Vogel, Angel Salas and licensee designee Nancy Harns.
03/23/2017	Contact - Telephone call made Called Williamston Police Department to request police reports.
03/23/2017	Contact - Telephone call made Left a voice mail for administrator Nancy Harns
3/23/2017	Contact – Telephone call received Spoke to Officer Stonebrook, who reported that the correct police department to contact is Meridian Township Police Department.
3/23/2017	Contact – Telephone call made Spoke to Meridian Township Police Department. Sent formal request to obtain police reports.
3/23/2017	Exit Conference Spoke to Nancy Harns via telephone.
04/07/2017	Contact – Telephone call made Spoke to Nancy Harns

ALLEGATION:

Resident A has been found wandering the neighborhood on several occasions by the local police department.

INVESTIGATION:

On 12/27/2016, a complaint was received which alleged that Resident A was found wandering the neighborhood on several occasions due to inadequate supervision.

On 12/28/2016, adult foster care licensing consultant, Leslie Barner, interviewed the complainant via telephone. The complainant reported that on 12/26/2016 as he exited his garage he observed Resident A standing outside cold, wet (it was raining), wearing no coat, confused and disoriented. Complainant stated that he brought Resident A inside and contacted the Meridian Township Police for assistance. Complainant stated it took about 15 minutes for police to arrive and during that time, his wife waited outside for police and also to see if she could locate anyone who may have been searching for Resident A. He stated they did not observe anyone looking for Resident A. Complainant stated that Resident A stated that she had walked all the way from Lansing and needed transportation back to Lansing. Complainant stated that Resident A told him that she left the Williamston Compassionate Care facility in a hurry, and without a coat, because someone was trying to hit her. Complainant stated there was an incident this past summer when the police were contacted and had to use dogs to locate a missing resident, but he does not know if that incident was regarding Resident A.

On 1/20/2017, adult foster care licensing consultant, Dawn Timm, conducted an on-site investigation at Williamston Compassionate Care. Mrs. Timm interviewed licensee designee, Nancy Harns. Mrs. Harns reported that Resident A has eloped four times since admission to the facility on 10/23/2016. Mrs. Harns reported that Resident A was returned to the facility on at least two occasions by the Meridian Township Police Department. Mrs. Harns reported that she installed an alarm at the front door in December 2016, in an effort to prevent Resident A from eloping from the facility.

Mrs. Timm interviewed staff member Rhonda Seno. Mrs. Seno reported that there was an incident in which Resident A eloped from the facility. Mrs. Seno reported that a police officer knocked on the window of the facility at approximately 4:30am, to inform her that Resident A was outside. Mrs. Reno did not provide an exact date of this incident, but informed Mrs. Timm that she was sleeping at the time of the incident and was not aware that Resident A had left the facility. Mrs. Seno stated she had no idea how long Resident A had been outside but she had not heard any alarm sound when Resident A left the facility.

Mrs. Timm interviewed staff member Shelly Stuber. Mrs. Stuber reported that Resident A eloped from the facility on 10/25/2016. Mrs. Stuber stated that she did not realize Resident A was missing for approximately 30 minutes, until she conducted a “head count.” Mrs. Stuber confirmed that door alarms were not installed in the facility until late December 2016.

I interviewed Mrs. Harns on 3/23/2017 and 4/7/2017. Mrs. Harns reported that she began using a GeoFence device in January 2017 in an effort to provide additional supervision to Resident A. Mrs. Harns stated that GeoFence is a device that is used to monitor and track Resident A’s location. The GeoFence is set up to allow Resident A to move throughout the premises of the facility, but an alarm will go off if Resident A goes outside of the parameter of the facility property. The GeoFence system does require Resident A to carry a tracking device to ensure proper monitoring. Mrs. Harns stated that Resident A is agreeable to carrying the tracking device. Mrs. Harns reported that Resident A has not had any elopement incidents since January 2017. Mrs. Harns reported that incident reports were not completed each time Resident A eloped, therefore it is unknown how many times Resident A eloped from the facility.

Mrs. Timm reported that she did not receive incident reports from Williamston Compassionate Care, reporting the elopements of Resident A.

I reviewed Resident A’s *Health Care Appraisal*, which stated that she has a medical diagnosis of Dementia. Resident A’s *Assessment Plan for AFC Residents* document, dated 10/26/2016, stated that Resident A ‘needs constant supervision’ when in the community.

I obtained police reports from Meridian Township Police Department, which confirmed that police responded to two incidents on 11/1/2016 and 12/26/2016 involving Resident A. In both incidents, Resident A had eloped from Williamston Compassionate Care Facility. On the 12/26/2016 incident, staff member Rita Vogel acknowledged that she did not know Resident A had eloped until the police arrived at the facility to return Resident A to the facility.

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:	Based on the above information and interviews with Mrs. Seno, Mrs. Stuber, and Mrs. Harns, the facility was aware of Resident A's medical diagnosis of dementia, elopement behavior, and need for supervision at all times, to ensure the safety and protection of Resident A. The facility was aware of Resident A's first elopement behavior on 10/25/2016, and did not implement safety measures until December 2016, approximately two months later. During this two month time frame, Resident A eloped at least four times. One of these instances occurred during the middle of the night, when police returned Resident A to the facility at approximately 4:30AM. Two other elopements also required local police involvement because direct care staff members were not aware that Resident A had eloped from the facility. Consequently, Resident A's protection and safety needs were not attended to at all times when she was allowed to elope from the facility on four separate occasions during all hours of the day, evening and nighttime, and for periods of at least 30 minutes before any staff member realized she was not in the facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(6) An accident record or incident report shall be prepared for each accident or incident that involves a resident, staff member, or visitor. "Incident" means a seizure or a highly unusual behavior episode, including a period of absence

	without prior notice. An accident record or incident report shall include all of the following information: **(a) The name of the person who was involved in the accident or incident.** **(b) The date, hour, place, and cause of the accident or incident.** **(c) The effect of the accident or incident on the person who was involved and the care given.** **(d) The name of the individuals who were notified and the time of notification.** **(e) A statement regarding the extent of the injuries, the treatment ordered, and the disposition of the person who was involved.** **(f) The corrective measures that were taken to prevent the accident or incident from happening again.**
ANALYSIS:	Based on the above information and an interview with Mrs. Harns, Williamston Compassionate Care did not complete any incident reports to document each time Resident A eloped from the facility, therefore it is unknown how many times Resident A eloped from the facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 1/20/2017, during the unannounced on-site investigation, Mrs. Timm reviewed medication records. During this review, Mrs. Timm found that the medication cabinet was unlocked and not supervised by any direct care staff member. A number of residents were in the dining area, where the medication cabinet is located, relaxing at the time of the unannounced on-site investigation. Prescription medications could have been easily accessed by residents.

On 9/29/2016, a Licensing Renewal Study was completed. During this on-site inspection, there were a number of loose prescribed medication pills found in three resident containers which held their medication bubble packs. Mrs. Harns did not have any explanation why there were three to five loose pills sliding around the bottom of the containers and no documentation on the medication administration record recording what happened to these loose pills. On 10/17/2016, licensee Nancy Harns submitted a Corrective Action Plan, which stated the following:

“Medication in-service review was conducted with the entire staff on October 12, 2016. The staff team members were directed to verify that all prescription

medication, including dietary supplements or individual special medical procedures are kept in the original pharmacy-supplied container, which shall be labeled for the specified resident and be kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required. Nancy Harns is responsible for implementing the corrective action and Williamston Compassionate Care is in compliance. Medications will be reviewed at each team meeting and verified on a continuous basis by Nancy Harns and staff team members to ensure compliance."

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being {333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	Based on the above information, the facility had prescription medication in an unlocked cabinet. The unlocked cabinet posed a potential safety risk to residents within the facility by allowing easy access to prescription medications.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED. LICENSING STUDY RENEWAL DATED 9/29/2016.**

INVESTIGATION:

Mrs. Timm reviewed the individual medication log for Resident B. Mrs. Timm observed no staff initials for the dates of 1/16/2016 at 8:00am, 1/17/2016 at 8:00pm, and 1/20/2016 at 8:00am.

Mrs. Timm reviewed the individual medication log for Resident C. Mrs. Timm observed no staff initials for administration of Resident C's PRN (take as needed) acetaminophen for the dates of 1/4/2016, 1/5/2016, 1/6/2016, 1/7/2016, 1/8/2016, 1/11/2016, 1/12/2016, 1/13/2016, 1/14/2016, 1/15/2016, 1/18/2016, and 1/19/2016. There was no reason documented in the medication log to explain the reason for administration of the medication.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(b) Complete an individual medication log that contains all of the following information:** **(i) The medication.** **(ii) The dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.** **(vi) A resident's refusal to accept prescribed medication or procedures.**
ANALYSIS:	Ms. Timm reviewed individual medication logs for Resident's B and C, and observed missing initials of the staff that administered the medication. Based on the above information, Williamston Compassionate Care failed to properly document and complete medication logs.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED. LICENSING STUDY RENEWAL DATED 9/29/2016.**

On 3/23/2017 and 4/7/2017, I conducted an Exit Conference with Nancy Harns. Mrs. Harns in agreement with the findings of this report.

III. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend that the status of the license remains the same.

5/08/2017

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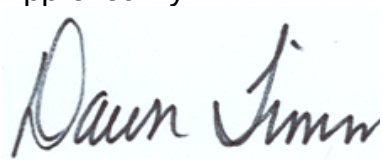
Stephanie Gonzalez Date
Licensing Consultant

Approved By:



05/22/2017

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Dawn N. Timm Date
Area Manager