RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

December 5, 2018

Ryan Goleski
The Haworth Center
30301 W. 13 Mile Road
Farmington Hills, MI 48334

RE: License #: AH630236793
Investigation #: 2019A1019010
The Haworth Center

Dear Mr. Goleski:

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 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 (248) 975-5053.

Sincerely,

Elizabeth Gregory-Weil, Licensing Staff
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(810) 347-5503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630236793
Investigation #:	2019A1019010
Complaint Receipt Date:	11/30/2018
Investigation Initiation Date:	11/30/2018
Report Due Date:	01/30/2019
Licensee Name:	Detroit Baptist Manor
Licensee Address:	30301 W 13 Mile Rd. Farmington Hills, MI 48334
Licensee Telephone #:	(810) 626-6100
Administrator:	Ryan Goleski
Authorized Representative:	Ryan Goleski
Name of Facility:	The Haworth Center
Facility Address:	30225 13 Mile Road Farmington Hills, MI 48334
Facility Telephone #:	(248) 539-3131
Original Issuance Date:	05/09/1999
License Status:	REGULAR
Effective Date:	11/18/2017
Expiration Date:	11/17/2018
Capacity:	59
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident D eloped from the facility.	Yes
Additional Findings	Yes

III. METHODOLOGY

11/30/2018	Special Investigation Intake 2019A1019010
11/30/2018	Special Investigation Initiated - Letter emailed administrator/AR for additional information
12/04/2018	Inspection Completed On-site
12/04/2018	Inspection Completed-BCAL Sub. Compliance
12/04/2018	Exit Conference Conducted with AR while onsite
12/05/2018	APS referral

ALLEGATION:

Resident D eloped from the facility.

INVESTIGATION:

On 11/26/18, licensing staff was notified via fax that Resident D eloped from the facility. The incident report with authored by facility administrator and authorized representative Ryan Goleski. The incident report read:

On the evening of 11-23-18 at approximately 10:00pm, [Resident D] went out of the Maple Hallway end door. This door is independently alarmed, but on camera the staff members didn't immediately attend to the alarm. When the staff realized that [Resident D] had gone out the door, they immediately ran outside to look for her. [Resident D] had walked into the parking lot across from the hallway end, and had gotten into a parked car that was somehow unlocked. As staff continued to sweep

the area and campus, they were unable to find [Resident D] anywhere. On-call staff and other staff on scene responded to the call. It was until I had the opportunity to fully review the incident that I saw [Resident D] trying to get into cars on camera. This is when I called and advised staff to look in every car on that side of the building. [Resident D] was found safe and unharmed in one of the cars at around 12:15am.

On 12/4/18, I conducted an onsite inspection. I interviewed Mr. Goleski at the facility. Mr. Goleski stated that Resident D does wander inside the facility, but only recently attempted to go outside. Mr. Goleski stated that Resident D has severe dementia and is not alert and oriented to person, place or time. Mr. Goleski stated that the facility does not have a secured memory care unit and all residents reside in general assisted living. Mr. Goleski stated that after her elopement on 11/23/18, staff have been advised to not let Resident D out of their sight but admitted that she is not receiving one on one supervision and that there are times when Resident D is left without staff oversight. Mr. Goleski stated that at the time of the incident, there were approximately 48 residents at the facility and four care staff working. Mr. Goleski stated that the facility was considered to be fully staffed at that time. Mr. Goleski stated that on 11/23/18 when the door alarms sounded, staff did not respond for 5-10 minutes and is unsure why they didn't respond immediately as it was on second shift during a period when staff are not typically very busy (no med passes, not serving meals, not providing showers, etc.) and many residents are already in bed. Mr. Goleski stated that two weeks prior on 11/8/18, Resident D got out of the building and was found in the apartment complex across the street. Mr. Goleski stated that after that incident staff were educated on police and procedures when a resident leaves the building without authorization.

The four care staff who were working second shift on 11/23/18 during Resident D's elopement were not present during my inspection. I requested statements from all staff that were working that evening but at the time of this report have not received those statements.

Resident D's service plan read "monitor where abouts- keep in sight- frequent visual checks", "will go out of/ through doorways. Constant monitor", "she has a wander bracelet on she does get out of the building occ [occasionally] we do have alarmed on the doors that will alert us when she goes out or tries to go out".

On 12/4/18, I observed that all facility exit doors had audible alarms but did not contain a locking mechanism on the inside. The doors also did not have a delayed egress so residents can freely walk out at any time without difficulty. There are currently no measures in place aside from the audible alarm to prevent residents from exiting the facility.

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.**
For Reference: 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. **(21) "Service plan" means a written statement prepared by the home in cooperation with a resident and/or the resident's authorized representative or agency responsible for a resident's placement, if any, and that identifies the specific care and maintenance, services, and resident activities appropriate for each individual resident's physical, social, and behavioral needs and well-being and the methods of providing the care and services while taking into account the preferences and competency of the resident.** **(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 D eloped on 11/8/18 and 11/23/18. On 11/8/18, Resident D's whereabouts were unknown for approximately 15 minutes and on 11/23 her whereabouts were unknown for more than two hours, placing her at great risk of harm while outside the facility unsupervised. According to accuweather.com, the temperatures on 11/8 reached a low of 35 degrees and a low of 27 degrees on 11/23. Mr. Goleski stated that Resident D suffers from "severe dementia". It is unreasonable to believe placement of a memory impaired individual into a general assisted living population with unrestricted access to the outdoors is in their best interest without qualified staff supervision. This practice places an unreasonable expectation that staff can assure memory impaired individuals remain safe by means of keeping Resident D within line of sight, despite staff admission that they are not always doing so. Based on these findings, the allegation is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

During my onsite inspection, Mr. Goleski disclosed that Resident D had a previous elopement attempt on 11/8/18 in which Resident D was outside for roughly 15 minutes before staff found her. I was unable to locate an incident report for that elopement and Mr. Goleski was not able to provide proof that the department was ever notified. Additionally, the 11/23/18 elopement was not reported to the department until 11/26/18.

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:	Resident D eloped from the facility on 11/8/18 and 11/23/18. The facility staff could not provide proof that the department was notified of the 11/8/18 elopement and the facility did not submit the 11/23/18 elopement incident report within the required timeframe. Based on these findings, the facility did not comply with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 12/4/18, I shared the findings of this report with facility authorized representative Ryan Goleski.

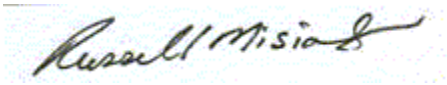
IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

12/5/18

Elizabeth Gregory-Weil Date
Licensing Staff

Approved By:



12/5/18

Russell B. Misiak Date
Area Manager