RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

January 4, 2019

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

RE: License #: AM330380484
Investigation #: **2019A0465008**
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.

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 #:	2019A0465008
Complaint Receipt Date:	11/05/2018
Investigation Initiation Date:	11/08/2018
Report Due Date:	01/04/2019
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:	03/23/2018
Expiration Date:	03/22/2020
Capacity:	12
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
On 11/5/2018, Resident A wandered away from the facility and staff were unaware of her whereabouts.	Yes

III. METHODOLOGY

11/05/2018	Special Investigation Intake 2019A0465008
11/07/2018	Contact - Telephone call made Left voice message for Complainant
11/08/2018	Special Investigation Initiated - Telephone
12/11/2018	Inspection Completed On-site
12/19/2018	Contact - Document Received Documents received via email from Mrs. Harns
01/02/2019	Exit Conference Conducted Exit Conference with Nancy Harns
01/02/2019	Inspection Completed-BCAL Sub. Compliance

ALLEGATION:

On 11/5/2018, Resident A wandered away from the facility and direct care staff were unaware of her whereabouts.

INVESTIGATION:

On 11/5/2018, a complaint was received, alleging that Resident A had wandered away from the facility and direct care staff were unaware of her whereabouts for an unknown amount of time. The complaint stated that on 11/5/2018, an elderly woman was observed walking down the street with no shoes on. The complaint stated that public citizens rushed Resident A to their vehicle and transported her back to the facility.

On 11/8/2018, I spoke to Complainant via telephone. Complainant reported that the information contained in the complaint is accurate.

On 12/11/2018, I conducted an onsite investigation at the facility. I reviewed Resident A's record, which stated that Resident A was admitted to the facility on 7/18/2018. The *AFC-Resident Information and Identification Record* stated that Resident A has a Designated Power of Attorney, Relative A1. The *Health Care Appraisal* listed Resident A's medical diagnoses as Dementia and Memory Impairment. The *Assessment Plan for AFC Residents* stated that Resident A requires supervision in the community, needs assistance with toileting, bathing, grooming, dressing, hygiene and uses a walker for mobility.

I interviewed staff member Shelly Stuber, who reported that she has worked at the facility for six years. Mrs. Stuber reported that she is familiar with Resident A. Mrs. Stuber reported that Resident A does have a history of wandering and she recalls that Resident A did wander away from the facility sometime during the month of November. However, Mrs. Stuber reported she was not working on that day and does not recall any specific details related to the incident. Mrs. Stuber did not report knowledge of any additional wandering by Resident A during the time that she has resided at the facility.

I interviewed staff member Darean Pennell, who reported that she has worked at the facility for one year. Mrs. Pennell reported that Resident A's "memory is not good, she tries to wander and we have to redirect her." Mrs. Pennell reported that Resident A can become agitated if she is not allowed to leave the facility and can be combative at times. Mrs. Pennell reported that Resident A has wandered away from the facility in the past, but that staff have followed her, and redirected her back to the facility. Mrs. Pennell reported no knowledge of Resident A wandering away from the facility without staff knowledge.

I interviewed staff member Shaniece Tucker, who reported that she is familiar with Resident A and has provided direct care to her on several occasions. Mrs. Tucker reported that Resident A has a history of wandering. Mrs. Tucker reported that when Resident A becomes agitated and "wants to go outside, a staff member will usually go out with her to supervise her." Mrs. Tucker reported that she is only aware of Resident A wandering away from the facility, without staff knowledge, on one occasion, on 11/5/2018. Mrs. Tucker reported that, on 11/5/2018, Resident A "had been trying to get out of the facility all day." Mrs. Tucker reported that it was cold outside and therefore she did not allow Resident A to go outside. Mrs. Tucker reported that she and staff member, Tanya Gilmore, were both very busy and did not realize that Resident A had wandered away from the facility. Mrs. Tucker reported that, at some point in the day, she was informed by another resident that Resident A was outside. Mrs. Tucker reported that she ran outside and observed Resident A being walked up the driveway by a public citizen. Mrs. Tucker reported she is unsure of exactly how long Resident A was gone, as she did not know when Resident A had left the facility. However, Mrs. Tucker reported that she remembered assisting Resident A with a clothing change approximately 10 minutes prior to discovering her outside. Mrs. Tucker reported that an incident report nor a police report was completed for this incident. Mrs. Tucker reported, "I only called Mrs. Harns."

I interviewed staff member Tanya Gilmore, who reported that she is familiar with Resident A and has provided direct care to her on several occasions. Mrs. Gilmore reported that Resident A has a history of wandering and that she can recall two times in which Resident A has wandered away from the facility. Mrs. Gilmore reported that one incident was prior to November 2018, and that on this occasion, a staff member followed Resident A into the community and redirected her back to the facility. Mrs. Gilmore reported the second incident in which Resident A wandered away from the facility occurred on 11/5/2018. Mrs. Gilmore reported that she was working on 11/5/2018, along with Mrs. Tucker. Mrs. Tucker reported that she did not know Resident A had wandered away until she was informed by Mrs. Tucker that Resident A was outside. Mrs. Gilmore reported that she did observe, from the front window, Resident A being brought back to the facility by a public citizen. Mrs. Gilmore acknowledged that Resident A requires supervision when in the community, to ensure her personal care, safety and protection needs are met.

On 1/2/2019, I spoke to Relative A1, who reported that she is the power of attorney for Resident A. Relative A1 reported that Resident A has a medical diagnosis of Dementia and has a history of wandering. Relative A1 reported that she did disclose to the facility at the time of admission that Resident A had a history of wandering and required constant supervision. Relative A1 reported that “it is a normal behavior for {Resident A} to wander.” Relative A1 reported she was unaware that Resident A had wandered away from the facility on 11/5/2018. Relative A1 did report that the facility is a “good place and the staff are tuned into the needs of the residents.” Relative A1 reported “I am very happy with the quality of care provided by the facility and have no concerns.”

On 1/2/2019, I conducted an Exit Conference with Mrs. Harns. Mrs. Harns acknowledged that Resident A has a history of wandering. Mrs. Harns reported that she was informed by Mrs. Tucker that Resident A had wandered away from the facility, but she believed that a staff member followed Resident A during this elopement. Mrs. Harns reported that she not aware that Resident A had wandered away from the facility without staff knowledge for approximately 10 minutes. Mrs. Harns reported that Resident A has not attempted to wander since the incident on 11/5/2018. Mrs. Harns reported that the facility has alarms on all of the exit doors to assist in preventing Resident A from wandering away from the facility. Mrs. Harns reported that she will ensure proper supervision is provided on an ongoing basis to prevent Resident A, as well as other residents, from wandering away from the facility. Mrs. Harns acknowledged that Resident A requires supervision when in the community, to ensure her personal care, safety and protection needs are met. Mrs. Harns reported that she has implemented numerous safety measures over the last 1 ½ years. Mrs. Harns reported that she has installed an ADT alarm system in the facility, that sounds an alarm each time an exit door is opened and requires a staff to enter a code to turn the alarm off. Mrs. Harns stated she also increased staffing to ensure that there are two staff on duty at all times. Mrs. Harns also reported that all exit doors in the facility have a chime sound that is made each time a door is

opened, as a way to alert staff to someone attempting to either enter or exit the building. Mrs. Harns reported that during the day time hours she is only utilizing the chime system and not the ADT alarm system. When asked why the ADT alarm system is not being utilized during the day time hours, Mrs. Harns replied, “I guess because it had not been an issue and I felt it was only necessary at night. I thought the chime would be sufficient during the day.” Mrs. Harns acknowledged that she should be utilizing the ADT alarm system on a 24 hour basis and agreed to implement this alarm system immediately, 24 hours a day, 7 days per week on a continuous basis.

Special Investigation Report #2017A0777005 dated 5/23/2017 cited violation of Rule 400.14305(3), regarding elopement of Resident B. The facility was aware of Resident B’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 B eloped at least four times. One of these instances occurred during the middle of the night, when police returned Resident B 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 B had eloped from the facility. Consequently, Resident B’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. Mrs. Harns submitted a Corrective Action Plan dated 6/26/2017, stating the following corrective measures would be implemented: An employee stays within contact of Resident C 24 hours a day. Also, the alarm system has been upgraded to secure the premises. Additional staff and upgraded alarm system secures Resident B. Nancy Harns is responsible for compliance. The corrective actions have taken place and an on-site visit from licensing confirmed the implementation of corrective actions has occurred. Staffing and upgraded alarm system will assure continued compliance.

Special Investigation Report #2017A0582006 dated 8/14/2017 cited violation of Rules 400.14303(2) and 400.14305(3) regarding elopement of Resident C, who had wandered away from the facility and was returned to the facility by the local police department. On 5/10/2017, Resident C eloped from the facility without the awareness of direct care staff. Ms. Stuber was asleep and was not monitoring Resident C or within contact of Resident C per the CAP submitted by Nancy Harns on 6/26/2017. Licensee designee and administrator Nancy Harns was aware of Resident C’s history of elopement from this facility, four times since her admission in October 2016, and diagnoses of Dementia. Yet despite this knowledge and the implementation of corrective measures such as Geo-fencing, increased staffing levels, an upgraded alarm system, and moving Resident C’s bedroom closer to direct care staff working stations, Resident C was still able to successfully elope from the facility on 5/10/2017 during the early morning hours between 3am and 5:30am requiring police intervention due to the lack of awareness by direct care staff. The protection and safety of Resident C was not attended to for approximately

1 ½ hours while she eloped. Resident C's assessment plan had not been updated to address the numerous elopement behaviors. Consequently, since Resident C's assessment plan was not updated to reflect her propensity to elope, direct care staff members were not fully knowledgeable of Resident C's specific elopement risks. A six-month provisional license was recommended and accepted by Mrs. Harns. Mrs. Harns submitted a Corrective Action Plan dated 9/15/2017, stating the following corrective measures were implemented effective 5/10/2017: An employee stays within contact of Resident C 24 hours a day. Also, the alarm system has been upgraded to secure the premises. Additional staff and upgraded alarm system secures Resident C. Nancy Harns is responsible for compliance. The corrective actions have taken place and an on-site visit from licensing confirmed the implementation of corrective actions has occurred. Staffing and upgraded alarm system will assure continued compliance.

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:	Resident A's *Assessment Plan for AFC Residents* states that she requires supervision in the community to ensure that her supervision, protection and personal care needs are attended to at all times. On 11/5/2018, Mrs. Tucker and Mrs. Gilmore acknowledged that Resident A wandered away from the facility without their knowledge and was gone for approximately 10 minutes prior to being returned to the facility by a public citizen. Based on the information above, on 11/5/2018, the facility did not ensure that Resident A's personal needs, protection and safety needs were attended to at all times as specified in Resident A's *Assessment Plan for AFC Residents.*
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED. [SEE SIR#2017A0582006 and Corrective Action Plan dated 9/15/2017]**

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 a review of Resident A's *Health Care Appraisal*, *Assessment Plan for AFC Residents* and interviews with Relative A1, Mrs. Gilmore, Relative A1, Mrs. Tucker and Mrs. Harns, Resident A does require supervision at all times, to ensure her safety and protection needs are met. On 11/5/2018, Mrs. Tucker and Mrs. Gilmore acknowledged that Resident A wandered away from the facility without their knowledge and was gone for approximately 10 minutes prior to being returned to the facility by a public citizen. Based on the information above, on 11/5/2018, the facility did not ensure that Resident A's personal needs, protection and safety needs were attended to at all times.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED. [SEE SIR#2017A0777005 and Corrective Action Plan dated 6/26/2017; SIR#2017A0582006 and Corrective Action Plan dated 9/15/2017]**

On 1/2/2019, I conducted an Exit Conference with Mrs. Harns. Mrs. Harns is in agreement with the findings of this report.

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, it is recommended that the status of the license remains unchanged.

Stephanie Gonzalez 1/3/2019

Stephanie Gonzalez Date
Licensing Consultant

Approved By:

Dawn Timm 01/04/2019

Dawn N. Timm Date
Area Manager