GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 28, 2021

Danielle Gill
Christian Care Assisted Living
1530 McLaughlin Avenue
Muskegon, MI 49442-4191

RE: License #: AH610236765
Investigation #: 2021A1010038
Christian Care Assisted Living

Dear Ms. Gill:

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 (616) 356-0183.

Sincerely,

Lauren Wohlfert, Licensing Staff
Bureau of Community and Health Systems
350 Ottawa, N.W. Unit 13, 7th Floor
Grand Rapids, MI 49503
(616) 260-7781
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH610236765
Investigation #:	2021A1010038
Complaint Receipt Date:	06/15/2021
Investigation Initiation Date:	06/15/2021
Report Due Date:	08/15/2021
Licensee Name:	Christian Care Inc.
Licensee Address:	1530 McLaughlin Ave. Muskegon, MI 49442
Licensee Telephone #:	(231) 722-7165
Authorized Representative/Administrator:	Danielle Gill
Name of Facility:	Christian Care Assisted Living
Facility Address:	1530 McLaughlin Avenue Muskegon, MI 49442-4191
Facility Telephone #:	(231) 777-3494
Original Issuance Date:	01/01/2000
License Status:	REGULAR
Effective Date:	07/07/2020
Expiration Date:	07/06/2021
Capacity:	105
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident C eloped from the facility on 6/12 and 6/13.	Yes
Additional Findings	Yes

III. METHODOLOGY

06/15/2021	Special Investigation Intake 2021A1010038
06/15/2021	Special Investigation Initiated - Letter APS referral emailed to Centralized Intake
06/15/2021	APS Referral APS referral emailed to Centralized Intake
06/15/2021	Contact - Telephone call made Interviewed the complainant by telephone
06/15/2021	Inspection Completed On-site
06/15/2021	Contact - Document Received Received Resident C's staff notes and service plan
06/28/2021	Exit Conference Completed with licensee authorized representative Danielle Gill

ALLEGATION:

Resident C eloped from the facility on 6/12 and 6/13.

INVESTIGATION:

On 6/15/21, the Bureau received the allegations from Adult Protective Services (APS). The complaint read, “[Resident C] has a cognitive impairment which includes exit seeking behaviors and a propensity to roam. The facility is aware of this. On 6/12/21 [Resident C] was found outside the building wandering around. A staff member brought her inside. On 6/13/21 [Resident C] got out again and was found a block or two away wandering near a busy road. [Resident C] got out of the facility a

year ago and a tethering device was purchased to hlp [sic] keep her in the home. It is unknown why the facility is no longer using this device."
On 6/15/21, I interviewed the complainant by telephone. The complainant was concerned Resident C eloped from the facility twice over a two-day period. The complainant reported Resident C exhibited exit seeking behavior in the past, however a wander guard device was not placed on Resident C until after her second elopement on 6/13. The complainant said Resident C was found on a busy street during one of the incidents. The complainant reported Resident C's needs would be better met in a secured memory care unit.

On 6/16/21, I interviewed administrator Danielle Gill at the facility. Ms. Gill reported a dietary staff person Jean Wall found Resident C outside on 6/12 and care staff person Jocelyn Gardner found her outside on 6/13. Ms. Gills stated Resident C did exhibit exit seeking behavior in the past. Ms. Gill said there was a document incident in November 2020 in which Resident C was exit seeking.

Ms. Gill stated the facility recently installed a wander guard system. Ms. Gill reported Resident C was sent to the emergency room (ER) after her elopement on 6/13. Ms. Gill said a wander guard device was placed on Resident C when she returned to the facility. Ms. Gill reported the wander guard device has been an effective intervention.

Ms. Gill provided me with a copy of Resident C's service plan for my review. The *ELOPEMENT RISK Directions* section of the plan read, "WANDER GUARD IN PLACE AT ALL TIMES- Provide supervision and redirection to avoid and prevent elopement. Provide checks throughout day/night and document whereabouts. If elopement occurs, following elopement procedures." The *Current Status* section of the *Elopement Risk* section read, "Requires supervision and redirection from staff to prevent elopement episodes. Exit-seeking and requires checks throughout day/night."

The *WANDERING RISK Directions* section of the plan read, "Wand Guard in place at all time. Provide supervision and redirection to avoid and prevent wandering episodes. If wandering occurs, determine follow-up plan." The *WANDER GUARD PLACEMENT Directions* section of the plan read, "Check placement (located on right wrist) of Wander Guard daily on every shift."

Ms. Gill provided me with a copy of Resident C's staff notes for my review. A note dated 11/12/20 read, "resident was found outside the facility walking up the drive way. When asking resident where she was going she stated that she had to move out and that she had another apartment down apple that she was moving into today. Resident seems very confused. Family was notified and doctor was paged. Waiting on a call back."

A note dated 11/26/20 read, "Resident has been trying to leave off the floor a couple times this morning. Resident said that her family got her a room on the 3rd floor and that's where she lives. Resident was redirected to her room." A note dated 6/12

read, “Resident was found at the corner of Creston Ave. 1st floor RCA had to go get resident. Kitchen staff found her and had called another employees [sic] phone stated resident was down there. RCA left facility to help get resident. Kitchen staff stayed with resident until RCA arrived and helped resident get into the RCA’s vehicle for transport back to the facility.”

A note dated 6/13 read, “Resident was found outside walking down drive way headed towards Creston Street. Tried to contact daughter but no luck. Resident was sent out to ER for evaluation.”

On 6/16/21, I interviewed dietary director Jean Wall at the facility. Ms. Wall reported as she was leaving the facility on 6/12, she observed Resident C walking on Creston street. Ms. Wall stated Resident C was walking with her walker and was wearing a long-sleeved jacket and long pants. Ms. Wall noted it was hot out on 6/12. Ms. Wall explained Resident C had food and water placed on her walker. Ms. Wall reported Resident C appeared tired from the long walk from the facility to Creston Street.

Ms. Wall said she called the facility to notify staff she found Resident C outside of the building. Ms. Wall reported additional dietary staff who were also leaving the facility and care staff arrived to help get Resident C back into the facility. Ms. Wall stated Resident C cooperated and got into one of the responding care staff person’s car.

Ms. Wall denied knowledge regarding Resident C’s previous exit seeking behavior.

On 6/16/21, I interviewed medication technician (med tech) Jocelyn Gardner at the facility. Ms. Gardner reported that on 6/13 a staff person was outside on a break and observed Resident C near a dumpster behind the facility. Ms. Gardner stated the staff person notified her Resident C was outside and asked for help getting her back into the building. Ms. Gardner stated this incident occurred in the mid-afternoon hours on 6/13, she was unable to recall the exact time.

Ms. Gardner said she was aware Resident C exhibited previous wandering behavior. Ms. Gardner reported Resident C can get combative when staff attempted to redirect her. Ms. Gardner stated Resident C’s care needs exceed what staff at the facility were able to provide her. Ms. Gardner explained staff interventions to redirect Resident C were not effective.

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.
ANALYSIS:	The interviews with Ms. Gill and Ms. Gardner, along with review of Resident C's staff notes revealed Resident C exhibited exit seeking behavior prior to her elopement incidents on 6/12 and 6/13. Staff at the facility did not ensure Resident C's safety or implement effective interventions to address Resident C's behavior. The circumstances that led up to the incidents on 6/12 and 6/13 revealed that the facility did not reasonably comply with this rule.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Special Investigation Report (SIR) 2021A1010032 dated 5/19/21**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 6/15/21, I reviewed the facility file. I did not receive any incident reports regarding Resident C's elopements on 6/12 and 6/13.

On 6/16/21, Ms. Gill reported she was in the process of completing incident reports regarding Resident C's elopements. Ms. Gill stated the reports will be submitted to licensing once they were completed. Ms. Gill acknowledged the incidents were passed the required 48-hour reporting time frame.

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.
For Reference: R 325.1901	**Definitions.**
	(17) "Reportable incident/accident" means an intentional or unintentional event in which a resident suffers harm or is at risk of more than minimal harm, such as, but not limited to, abuse, neglect, exploitation, or unnatural death.
ANALYSIS:	Review of the facility file, as well as the interview with Ms. Gill, revealed incident reports regarding Resident C's elopements on 6/12 and 6/13 were not reported to licensing within the required reporting timeframe.
CONCLUSION:	**VIOLATION ESTABLISHED**

I shared the findings of this report with licensee authorized representative Danielle Gill by telephone on 6/28. Ms. Gill and I discussed assessing current resident acuity levels and residents at risk of elopement as part of the corrective action plan. Ms. Gill understood the importance of identifying residents who required care beyond what the facility could provide.

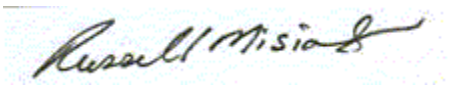
IV. RECOMMENDATION

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

6/22/21

Lauren Wohlfert Date
Licensing Staff

Approved By:



6/22/21

Russell B. Misiak Date
Area Manager