GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 31, 2021

Steven Tyshka
Waltonwood at Twelve Oaks II
27495 Huron Cr.
Novi, MI 48377

RE: License #: AH630264366
Investigation #: 2021A0784047
Waltonwood at Twelve Oaks II

Dear Mr. Tyshka:

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 (810) 787-7031.

Sincerely,

Aaron L Clum

Aaron Clum, Licensing Staff
Bureau of Community and Health Systems
4809 Clio Road
Flint, MI 48504
(517) 230-2778

enclosure

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

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AH630264366 |
| | |
| **Investigation #:** | 2021A0784047 |
| | |
| **Complaint Receipt Date:** | 08/20/2021 |
| | |
| **Investigation Initiation Date:** | 08/20/2021 |
| | |
| **Report Due Date:** | 10/20/2021 |
| | |
| **Licensee Name:** | Waltonwood at Twelve Oaks II, LLC |
| | |
| **Licensee Address:** | Ste. #200<br>7125 Orchard Lake Rd.<br>West Bloomfield, MI 48322 |
| | |
| **Licensee Telephone #:** | (248) 865-1600 |
| | |
| **Administrator:** | Gina Steigerwald |
| | |
| **Authorized Representative:** | Steven Tyshka |
| | |
| **Name of Facility:** | Waltonwood at Twelve Oaks II |
| | |
| **Facility Address:** | 27495 Huron Cr.<br>Novi, MI 48377 |
| | |
| **Facility Telephone #:** | (248) 735-1030 |
| | |
| **Original Issuance Date:** | 01/25/2005 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 03/11/2021 |
| | |
| **Expiration Date:** | 03/10/2022 |
| | |
| **Capacity:** | 94 |
| | |
| **Program Type:** | AGED<br>ALZHEIMERS |

## II. ALLEGATION(S)

| | Violation Established? |
|---|---|
| Resident A was inadequately supervised | Yes |
| Additional Findings | Yes |

## III. METHODOLOGY

| | |
|---|---|
| 08/20/2021 | Special Investigation Intake<br>2021A0784047 |
| 08/20/2021 | Special Investigation Initiated - Telephone<br>Interview with administrator Gina Steigerwald |
| 08/20/2021 | Contact - Document Sent<br>Request for investigative documentation/information |
| 08/23/2021 | Contact - Document Received<br>Investigative documents received from Ms. Steigerwald by email |
| 08/31/2021 | Exit Conference – Telephone<br>Conducted with authorized representative Steven Tyshka |

Due to the Covid19 pandemic, this investigation was completed remotely.

**ALLEGATION:**

**Resident A was inadequately supervised**

**INVESTIGATION:**

The department received an incident report from the facility which indicated that on 8/13/21 at 1:20pm, “Resident exited out of community through the independent living front entrance and walked across the street to the store in Twelve Oaks Mall. Resident was absent from the community approximately 3 hours. Community staff escorted resident back to community. Care staff reviewed plan of care with family, family member decided to take resident home to provide one on one supervision. Resident ambulates independently without devices. Resident has history of forgetfulness, confusion and wandering. She was dressed appropriately, wearing proper footwear”.

On 8/20/21, I interviewed administrator Gina Steigerwald by telephone. Ms. Steigerwald stated that on 8/13/21, Resident A exited through a shared door from the assisted living to the independent living area of the

building. Ms. Steigerwald stated this door stays locked and can only be accessed by staff. Ms. Steigerwald stated she reviewed camera footage of the incident which showed marketing manager, Ashley Hecksel holding the door open for Resident A. Ms. Steigerwald stated that when she questioned Ms. Hecksel about opening the door, Ms. Hecksel reported being certain she saw a staff member with Resident A at the time. Ms. Steigerwald stated that at approximately between 4:30 and 4:45pm on 8/13 the facility received a phone call from Resident AR stating Resident A had just called her and asked for a ride home as she was at the Twelve Oaks Mall. Ms. Steigerwald stated the facility essentially shares a parking lot with the mall so associate executive director Haylee Hutchinson and resident care director Binita Patel walked over to the mall and escorted Resident A back to the facility. Ms. Steigerwald stated Resident A is a person who is prone to wandering and likes to walk through the facility. Ms. Steigerwald stated Resident A had not previously displayed exit seeking behaviors. Ms. Steigerwald stated Resident AR decided to move Resident A out of the facility to take her home. Ms. Steigerwald stated that until receiving notification from Resident AR, facility staff were not aware of Resident A's absence. Ms. Steigerwald stated staff are supposed to check on Resident A every 2 hours throughout the day.

I reviewed Resident A's service plan. Within a section titled *Safety*, the plan reads, in part, "wellness check every 2 hours during day/afternoon". Within a section titled *Escorts*, the plan reads, in part, "extensive wandering issues, [Resident A] has a history of leaving immediate area, getting lost, or being combative about returning. Requires supervision. [Resident A is not to leave the community unaccompanied".

| **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:**<br><br>**(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.**<br><br>**(22) "Supervision" means guidance of a resident in the activities of daily living, and includes all of the following:**<br><br>**(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:** | Facility incident reporting indicated Resident A exited the building on 8/13/21 and was absent for approximately 3 hours before being brought back to the facility. The investigation revealed that not only was Resident A absent for 3 hours, but staff were not aware of her absence until contacted by Resident AR who had been contacted by Resident A asking for a ride home from the mall. In addition, Resident A's plan identified her as an "extensive wander". Despite this fact, the plan only had staff monitor her every two hours. This extended time seems unreasonably long for an individual with cognitive deficits and wandering behaviors. Given the fact the resident was absent for an entire hour without monitoring it is clear the facility lacks an organized program of protection and supervision. Based on the findings, the facility is not in compliance with this rule. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**ADDITIONAL FINDING:**

**INVESTIGATION:**

When interviewed, Ms. Steigerwald stated that on 8/13/21, when Resident A left the facility, the facility was short staffed. Ms. Steigerwald one caregivers and one medication technician (med tech) are normally assigned to the area Resident A was living in, the first floor assisted living during first and second shift. Ms. Steigerwald stated that the assigned caregiver on first left at 12pm that day leaving only the med tech for the rest of the shift. Ms. Steigerwald stated that the caregiver assigned to work second shift did not come in that day. Ms. Steigerwald stated med techs can and do help with providing care when they are not passing medications. Ms. Steigerwald stated she believed the regular rooms checks were not conducted that day due to being short staffed. Ms. Steigerwald stated administrative staff do help out on the floor as well, but that it can be difficult to complete all tasks without the necessary care staff.

I reviewed the staff schedule for 8/13/21, provided by Ms. Steigerwald. The schedule was consistent with statements provided by Ms. Steigerwald. According to the schedule, the staff member that did work on first shift that day only worked a partial shift until 12pm and the schedule indicated no caregiver came in to work on second shift.

| **APPLICABLE RULE** | |
|---|---|
| **R 325.1931** | **Employees; general provisions.** |
| | **(5) The home shall have adequate and sufficient staff on duty at all times who are awake, fully dressed, and capable of providing for resident needs consistent with the resident service plans.** |
| **ANALYSIS:** | The investigation revealed that on 8/13/21, during first and second shift when Resident A exited the building, the assisted living was short staffed. Based on the findings the facility is not in compliance with this rule. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

On 8/31/21, I discussed the findings of the investigation with authorized representative Steven Tyshka.

## IV. RECOMMENDATION

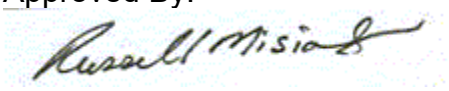
Upon receipt of an acceptable corrective action plan, it is recommended that the status of the license remain unchanged.

Aaron L Clum 8/27/21

_____

Aaron Clum Date
Licensing Staff

Approved By:



8/27/21

_____

Russell B. Misiak Date
Area Manager