GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 30th, 2021

Kristen Nitz
Senior Living Boulder Creek, LLC
7927 Nemco Way, Ste 200
Brighton, MI 48116

RE: License #:	AH410406207
Investigation #:	2021A1021043
	Boulder Creek Assisted Living & Memory Care

Dear Ms. Nitz:

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 (517) 284-9730.

Sincerely,

Kimberly Horst, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH410406207
Investigation #:	2021A1021043
Complaint Receipt Date:	08/16/2021
Investigation Initiation Date:	08/18/2021
Report Due Date:	10/15/2021
Licensee Name:	Senior Living Boulder Creek, LLC
Licensee Address:	7927 Nemco Way, Ste 200 Brighton, MI 48116
Licensee Telephone #:	(616) 464-1564
Administrator:	Lauren Wu
Authorized Representative:	Kristen Nitz
Name of Facility:	Boulder Creek Assisted Living & Memory Care
Facility Address:	6070 Northland Drive Rockford, MI 49341
Facility Telephone #:	(616) 866-2911
Original Issuance Date:	08/10/2021
License Status:	TEMPORARY
Effective Date:	08/10/2021
Expiration Date:	02/09/2022
Capacity:	108
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A eloped from the building.	Yes
Resident A's medications were not administered.	No
Additional Findings	No

III. METHODOLOGY

08/16/2021	Special Investigation Intake 2021A1021043
08/18/2021	Special Investigation Initiated - On Site
08/19/2021	Contact-Telephone call made Interviewed caregiver Mumina Ciise
08/23/2021	Contact-Documents Received Received service plan
08/30/2021	Exit Conference Exit Conference with authorized representative Kristen Nitz

ALLEGATION:

Resident A eloped from the building.

INVESTIGATION:

On 8/16/21, the licensing department received a complaint with allegations Resident A eloped from the building on 8/13/21. The complaint was sent from Adult Protective Services (APS).

On 8/18/21, I interviewed administrator Lauren Wu at the facility. Ms. Wu reported Resident A was in memory care due to cognitive decline. Ms. Wu reported the past few weeks, Resident A started to exhibit exit seeking behaviors by standing near the exit doors. Ms. Wu reported on 8/10, Resident A's primary care physician saw Resident A in the facility and increased his Risperdal dose to 1mg three times a day. Ms. Wu reported on 8/11, the receptionist opened the front door for another resident and Resident A was able to exit the building behind the other resident. Ms. Wu

reported a staff member saw Resident A in the parking lot and escorted Resident A back into the building. Ms. Wu reported following this incident, all staff were re-educated on the door policy. Ms. Wu reported if the door is opened, the staff member cannot leave the door until it is closed. Ms. Wu reported Resident A was then placed on 30-minute checks. Ms. Wu reported on 8/11, Resident A was sent to the emergency room for increased behaviors and agitation. Ms. Wu reported he was sent back later that evening with new medication orders for new diagnosis of pneumonia. Ms. Wu reported the facility was working with the family on possibly arranging 1:1 care or a discharge to a more secure facility. Ms. Wu reported on 8/13 Resident A pushed the exit door on the White Pine hallway and was able to get outside. Ms. Wu reported staff members immediately responded to the alarm, but Resident A was already outside. Ms. Wu reported Resident A was able to walk through the parking lot and went onto the divided highway. Ms. Wu reported it took several staff members to get Resident A back into the building. Ms. Wu reported emergency medical services were then called for possible transfer to the emergency room for a psychological evaluation. Ms Wu reported the family refused transfer. Ms. Wu reported the facility and the family arranged for 1:1 care. Ms. Wu reported the family was to provide 1:1 care on the evening of 8/14. Ms. Wu reported when the family was called to come in, they refused and asked for the resident to be transferred to the emergency room. Ms. Wu reported Resident A is still in the hospital system and will discharge to Story Point of Rockford because it is a more secure unit. Ms. Wu reported the memory care residents can move about the facility as the unit is not a locked unit.

On 8/18/21, I interviewed caregiver Leslie See at the facility. Ms. See reported Resident A would stand at the doors to attempt to exit seek. Ms. See reported Resident A recently had increased exit seeking behaviors by looking for doors that were opened. Ms. See reported Resident A would walk the hallways and would not stay in the memory care unit. Ms. See reported the facility tried to keep Resident A from exit seeking but was unable to do so.

On 8/19/21, I interviewed caregiver Mumina Ciise by telephone. Ms. Ciise reported she worked with Resident A on 8/12 and Resident A was exit seeking. Ms. Ciise reported she was able to get Resident A to stay in memory care, complete activities, and eat meals but he kept trying to leave the facility. Ms. Ciise reported she also provided care to Resident A on 8/13. Ms. Ciise reported Resident A was exit seeking and made comments about leaving the facility. Ms. Ciise reported Resident A ate dinner and then left the building. Ms. Ciise reported she responded to a door alarm and observed Resident A outside the building. Ms. Ciise reported she went after Resident A and attempted to re-direct him back to the building. Ms. Ciise reported she was unable to do so, and Resident A walked across the parking lot and into the road. Ms. Ciise reported the road was very busy with traffic. Ms. Ciise reported Relative A1 was driving by and observed Resident A outside the facility. Ms. Ciise reported Relative A1 assisted Resident A back into the facility. Ms. Ciise reported Resident A was on frequent checks but could not recall the frequency of checks.

I reviewed chart notes for Resident A. The chart notes read,

"8/7: Resident has been exit seeking during shift.
8/7: Resident was exit seeking most of the shift and was redirected multiple times by multiple staff.
8/8: Resident ate dinner well. Resident was exit seeking most of the evening and was redirected by multiple staff.
8/9: Res exit seeking all day made door alarms go off all shift in (assisted living) wouldn't eat lunch wouldn't stay in (memory care) would not be redirected
8/11: resident did get out into the parking lot and was aggressive with staff trying to get him to come back into the building.
8/12: res is exit seeking res got out the front door but was redirected by staff
8/13: Staff hear the alarm and went to go reset it but saw resident was out and walking toward traffic and run to redirect resident back to the facility but resident kept getting closer to the street and jumped staff into on coming traffic and was unable to redirect resident. Son was passing by boulder creek and saw son and staff in the middle of the road and tried helping to redirect resident. Resident was brought back to the facility and admin spoke with family and family decided to keep resident in facility and not sent him to pine rest and declined the ambulance.
8/14: Resident started exit seeking behavior beginning of shift and Admin recommend that staff call family and notified them of this and son said he would come to visit but around dinner time son called again and said to sent him. 911 was called and ambulance took residents and resident is getting a psych evaluation and will not be returning tonight."

I reviewed the service plan for Resident A. The service plan read,

"*Has limited safety awareness and needs to be supervised outside on campus grounds. May stay in secured area unsupervised. Must have supervision for off campus trips. Does not wander. Report any wandering or exit seeking."*

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: 325.1901	**Definitions.**

	(22) "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 A was known to exit seek and at times was uncooperative with staff redirection. Resident A exhibited all these behaviors between 8/7-8/13. Resident A's plan was not updated during this six day period to reflect his increasing need for supervision. Specifically, it lacked the frequency of time staff were to spend with him and the level of one-to-one supervision he required due to his consistently demonstrated behaviors and his cognitive deficits. Due to this insufficiently developed plan, staff were not aware of his whereabouts allowing him to elope unnoticed and at risk of harm by crossing a busy road. The facility lacked an organized program of supervision and reasonable protective measures to keep him safe.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A's medications were not administered.

INVESTIGATION:

The complaint alleged Resident A was prescribed psychotic medications that were not administered.

Ms. Wu reported on 8/10 Resident A's physician saw the resident in the facility. Ms. Wu reported the physician prescribed Risperidone 1mg with instructions to administer three times daily. Ms. Wu reported this was an increased in Risperidone dosage for Resident A. Ms. Wu reported this medication was delivered and started on 8/12. Ms. Wu reported when a physician changes a medication it can take a few days to receive the order and begin the medication. Ms. Wu reported there was no delay in starting this medication. Ms. Wu reported Resident A was administered medications according to the physician orders.

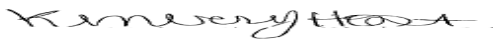
I reviewed the medication administration record (MAR) for Resident A. The MAR revealed Resident A was prescribed Risperidone Tab1mg with instruction to administer one tablet by mouth three times daily. This medication was ordered on 8/10. The MAR revealed Resident A received this medication 8/12-8/13.

APPLICABLE RULE	
R 325.1932	**Resident Medications.**
	(1) Medication shall be given, taken, or applied pursuant to labeling instructions or orders by the prescribing licensed health care professional.
ANALYSIS:	Review of Resident A's MAR revealved Resident A received medications according to the physician orders.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 8/30/21, I conducted an exit conference with authorized representative Kristen Nitz by telephone. Ms. Nitz reported the licensee is in the process of securing the memory care unit to prevent future elopements from occurring.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the status of the license.



8/23/21

Kimberly Horst Date
Licensing Staff

Approved By:

8/27/21

Russell B. Misiak Date
Area Manager