GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 18, 2022

Todd Dockerty
The Reflections
14316 S. Helmer Rd.
Battle Creek, MI 49015

RE: License #: AH130403566
Investigation #: 2022A1028012
The Reflections

Dear Mr. Dockerty:

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 I am not available, and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,
Julie Viviano, Licensing Staff
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
Cell 616-204-4300

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

I. IDENTIFYING INFORMATION

License #:	AH130403566
Investigation #:	2022A1028012
Complaint Receipt Date:	11/17/2021
Investigation Initiation Date:	11/17/2021
Report Due Date:	1/18/2022
Licensee Name:	Battle Creek Assisted Living Operator, LLC
Licensee Address:	111 W. Ferry St. #1 Berrien Springs, MI 49103
Licensee Telephone #:	(574) 261-1124
Administrator:	Jonathan Zima
Authorized Representative:	Todd Dockerty
Name of Facility:	The Reflections
Facility Address:	14316 S. Helmer Rd. Battle Creek, MI 49015
Facility Telephone #:	(269) 969-2500
Original Issuance Date:	12/09/2020
License **Status:**	REGULAR
Effective Date:	06/09/2021
Expiration Date:	06/08/2022
Capacity:	45
Program Type:	ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A eloped from the building.	Yes
Additional Findings	Yes

III. METHODOLOGY

11/17/2021	Special Investigation Intake 2022A1028012
11/17/2021	Special Investigation Initiated - Letter APS referral emailed to Centralized Intake
11/17/2021	APS Referral APS referral emailed to Centralized Intake
12/20/2021	Inspection Completed On-site 2022A1028012
12/20/2021	Contact - Face to Face Interviewed Admin/Jonathan Zima at the facility.
12/20/2021	Contact - Face to Face Interviewed Exc. Director/Cortney Banker at the facility.
12/20/2021	Contact - Face to Face Interviewed care staff Destiny Jones at the facility.
12/20/2021	Contact - Face to Face Interviewed care staff Chelsea Evans at the facility.
12/20/2021	Contact - Face to Face Interviewed care staff Brittney Brooks at the facility.
12/20/2021	Contact - Face to Face Interviewed maintenance person Jeff Barnaby at the facility
12/22/2021	Contact – Telephone call made Interviewed Resident A’s authorized representative by telephone

01/18/2022	Exit Interview

ALLEGATION:

Resident A eloped from the building.

INVESTIGATION:

On 11/17/21, the Bureau received the allegations from a facility elopement report.

On 12/20/21, I interviewed administrator, Jonathan Zima, at the facility. Mr. Zima reported Resident A eloped through the front doors on 11/14/21. Mr. Zima reported the front doors can be locked and unlocked by a keypad, key fob, or key. Mr. Zima reported the green light on the keypad notifies the door is unlocked and the red light notifies the door is locked. Mr. Zima reported there are cameras at the front entrance of the facility and the video footage showed Resident A exiting through the front door due to a care staff person completing "the lock procedure too many times, causing the door alarm to malfunction and unlock instead of lock". Mr. Zima also reported the light did not notify the care staff person the door was unlocked. Mr. Zima reported the elopement occurred during second shift and there was not a care staff person at the front desk then.

On 12/20/21, I interviewed executive director, Cortney Banker, at the facility. Ms. Banker reported Resident A does not exhibit elopement behavior and this was Resident A's first elopement. Ms. Banker reported Resident A exited the facility unattended on 11/14 and was gone from the facility for 20 minutes. A passerby saw Resident A and brought Resident A back to the facility. Ms. Banker reported the door was unarmed at 8:32pm. Ms. Banker reported there is not a staff member always stationed at the front desk of the facility. Ms. Banker reported after reviewing the video footage of Resident A's elopement, it was determined a staff member did not alarm the door correctly, even though it appeared to be alarmed and Resident A was able to elope easily through the front doors. Ms. Banker reported the care staff member who did not alarm the door correctly, along with all other facility staff were re-educated and retrained on alarming the front doors correctly. Ms. Banker reported APS and police were not notified of this incident, as care "staff did not realize [Resident A] was gone until the passerby brought [Resident A] back to the facility". Ms. Banker provided Resident A's service plan with record notes, the elopement incident report, the facility elopement policy, staff re-training and education in-service document on facility elopement, and the care staff schedule for the month of November 2021.

On 12/20/21, I interviewed care staff person (CSP), Destiny Jones, at the facility. Ms. Jones reported she was not working when Resident A eloped through the front doors of the facility but reported the alarm should have been directly linked to the care staff

pagers to notify the care staff the front door alarm was compromised. Ms. Jones reported she heard from “other staff the front door did not alarm go off” and she is unsure how the front door became disarmed so Resident A could elope. When asked, Ms. Jones reported to her knowledge there was no care staff at the front desk due to it being later in the evening of second shift. Ms. Jones reported after the elopement, the entire care staff was retrained on alarming and disabling the alarm system. Ms. Jones also reported she was trained at orientation on the alarm system as well. Ms. Jones reported Resident A does not have a history of eloping but does like to stay in the main lobby area near the front doors. Ms. Jones reported Resident A is easy to redirect away from the front doors if needed. Ms. Jones was able to explain how to alarm and disarm the front doors when questioned.

On 12/20/21, I interviewed CSP, Chelsea Evans, at the facility. Ms. Evans reported she was not working during the time Resident A eloped but had knowledge that Resident A eloped through the front doors due to a care staff not alarming the door correctly. Ms. Evans reported Resident A had not demonstrated elopement behaviors prior to the elopement but does like to “stand by the doors” in the front area of the facility. Ms. Evans reported to her knowledge there was no care staff person at the front desk when Resident A eloped. Ms., Evans reported she was trained at orientation and all staff received additional training on alarming and disarming the front doors after Resident A eloped. Ms. Evans was able to explain how to alarm and disarm the front doors when questioned.

On 12/20/21, I interviewed CSP, Brittney Brooks, at the facility. Ms. Brooks reported she had just begun recently working at the facility and was not working during the time of the elopement. Ms. Brooks reported she is unsure if there was a care staff person at the front desk during Resident A’s elopement. Ms. Brooks reported she was trained at orientation and again after Resident A’s elopement on how to alarm and disarm the front doors. Ms. Brooks reported to her knowledge Resident A does not exhibit elopement behaviors but does like to be near the front doors of the main entrance. Ms. Brooks reported Resident A is easy to redirect away from the doors.

On 12/20/21, I interviewed maintenance person, Jeff Barnaby, at the facility. Mr. Barnaby reported knowledge of Resident A’s elopement through the front doors on 11/14 and reported this was the “first elopement in years” at the facility. Mr. Barnaby reported the alarm system was serviced immediately after the elopement and he re-trained staff on all three shifts on how to alarm and disarm the front doors correctly. Mr. Barnaby reported the training also included understanding policy, what to do in case of a power outage, and how to reset the alarm system. Mr. Barnaby reported he completes alarm training and education throughout the year as well. Mr. Barnaby reported the alarm can be locked or unlocked using the keypad, key fob, or key and he is unsure if the alarm failed or if it was unlocked accidently by care staff resulting in Resident A eloping through the front doors. Mr. Barnaby also reported there are cameras at the front door entrance as well and the camera footage was reviewed showing Resident A walking out the front doors. Mr. Barnaby reported there have

been no issues with the alarm since the alarm was serviced and since all staff were re-trained.

On 12/22/21, I interviewed Resident A's authorized representative by telephone. The authorized representative reported Resident A eloped from the facility on 11/14 and [they] were told Resident A went next door to the adjacent building and that Resident A was not gone that long, "only a few minutes". The authorized representative reported [they] were later approached by a facility employee and were told the following about Resident A's elopement:

- Resident A eloped from the facility for 20 minutes or more.
- Resident A was found by a good Samaritan that had been driving down the road. The good Samaritan brought Resident A back to the facility in a car.
- The good Samaritan took Resident A to The Heritage thinking that was where Resident A belonged.
- A staff member from The Reflections was called over to take [Resident A] back to the correct building.

The authorized representative reported care staff did not know Resident A was even missing from the facility until Resident A was brought back to the facility by the good Samaritan. The authorized representative while they were notified of the incident by the facility shortly after it occurred, concern was expressed "about not being told the truth initially" by care staff concerning Resident A's elopement. The authorized representative reported great concern about "how this potentially could have been a very bad outcome for [Resident A] had someone not found [Resident A] in time". The authorized representative reported to [their] knowledge there was not a care staff person at the front desk when Resident A eloped "probably because it is second shift in the evening, but if they had checked on [Resident A] they would have known [Resident A] was gone". The authorized representative reported Resident A does not have any memory of the elopement incident.

On 12/20/21, I completed an onsite inspection. I observed Resident A in the main front lobby area. Resident A was clean, groomed and content.

During the inspection, I also observed a care staff member training another care staff member on how to alarm the front doors.

On 12/27/21, I completed a review of Resident A's service plan. The review revealed the following:

- Resident A's service plan was last updated 7/12/21.
- Resident A requires 2-hour checks as needed. Resident A must also be signed in and out of the facility and cannot leave the facility without assist.
- Resident A requires reminders for meals and promoting for social events.
- Resident is independent with toileting, ambulation, and transfer.
- Resident A requires assist with hygiene, showering, dressing, and functional communication (prompting and redirecting as needed).

Review of Resident A's record notes revealed behavioral incidents on 8/5, 8/13, 9/30, and 10/15 in which Resident A had either demonstrated outburst(s) and/or demonstrated wandering in the front lobby area during the late afternoon or evening shifts, requiring redirection from care staff.

Review of the facility elopement policy read:

- *The front doors of the Reflections are armed 24/7. All other doors are armed and locked at all times as well.*
- *Resident aides carrying beepers will know which door has been opened by the sounding alarm.*
- *Staff will respond immediately to the sounding of the alarms.*

The review of the in-service elopement drill document revealed the standard operating procedures were reviewed with facility staff on 11/15 and 11/16.

The review of the working staff schedule for 11/14 revealed there was a shift supervisor, a med tech, and two care aides working during the time of Resident A's elopement.

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:	Resident A eloped through the front doors of the facility on 11/14. The facility has an alarm system with cameras and elopement policy in place. There is evidence care staff working at the time of Resident A's elopement did not provide the necessary 2-hour checks to account for Resident A's whereabouts prior to the elopement and in accordance with the service plan. There is also evidence care staff were aware Resident A often had to be redirected away from the front doors of facility entrance on multiple occasions prior to the elopement. Also, care staff did not realize Resident A had even eloped outside of the facility or that Resident A was missing for at least 20 minutes. Care staff did not alarm the front doors correctly and did not ensure the front doors were appropriately locked, compromising Resident A's safety.
CONCLUSION:	**VIOLATION ESTABLISHED**

Additional Findings:

On 12/22/21, Resident A's authorized representative reported to [their] knowledge no changes had been made to Resident A's service plan since the recent elopement. The authorized representative reported to [their] knowledge, the service plan was last updated in July 2021 and that no one from the facility has made any attempt or contacted [them] to update safety measures for Resident A since the recent elopement.

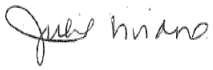
On 12/22/21, I reviewed Resident A's service plan and record notes. The review revealed the service plan was last updated 7/12/21. Review of the record notes revealed Resident A demonstrated wandering in the front lobby area since August 2021 and prior to the elopement.

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(5) A home shall update each resident's service plan at least annually or if there is a significant change in the resident's care needs. Changes shall be communicated to the resident and his or her authorized representative, if any.

ANALYSIS:	Resident A's service plan does not reflect any new changes to ensure Resident A's safety. There are no preventative and/or corrective measures in the service plan addressing Resident A's recent elopement.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Continent upon an approved corrective action plan, I recommend the status of this license remain unchanged.



12/28/21

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Julie Viviano Date
Licensing Staff

Approved By:

01/13/2022

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Andrea L. Moore, Manager Date
Long-Term-Care State Licensing Section