GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 28, 2022

Diane Vondette
Comfort Care Senior Living LLC
4180 Tittabawassee
Saginaw, MI 48603

RE: License #: AL790406037
Investigation #: 2022A0871032
Vassar Comfort Care II

Dear Ms. Vondette:

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 (989) 732-8062.

Sincerely,

Kathryn A. Huber, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48605
(989) 293-3234

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL790406037
Investigation #:	2022A0871032
Complaint Receipt Date:	04/04/2022
Investigation Initiation Date:	04/07/2022
Report Due Date:	06/03/2022
Licensee Name:	Comfort Care Senior Living LLC
Licensee Address:	4180 Tittabawassee Saginaw, MI 48603
Licensee Telephone #:	(989) 233-4954
Administrator:	Emily Matuszak
Licensee Designee:	Diane Vondette
Name of Facility:	Vassar Comfort Care II
Facility Address:	5840 Frankenmuth Vassar, MI 48768
Facility Telephone #:	(989) 882-9495
Original Issuance Date:	01/22/2021
License Status:	REGULAR
Effective Date:	07/22/2021
Expiration Date:	07/21/2023
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED AGED

	ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
On April 2, 2022, Resident A was observed to be on her hands and knees waving traffic down for help. Resident A was confused, had no coat and was wearing only slippers. There was no one observed in the area to be looking for her.	Yes

III. METHODOLOGY

04/04/2022	Special Investigation Intake 2022A0871032
04/07/2022	Special Investigation Initiated - Telephone Telephone call to Complainant 1
04/20/2022	Inspection Completed On-site Interviewed Administrator Emily Matuszak and Staff Ashley Rau
04/20/2022	Exit Conference Face to face exit conference with Administrator Emily Matuszak
04/21/2022	APS Referral Through Central Intake to Tuscola County MDHHS

ALLEGATION:

On April 2, 2022, Resident A was observed to be on her hands and knees waving traffic down for help. Resident A was confused, had no coat and was wearing only slippers. There was no one observed in the area to be looking for her.

INVESTIGATION:

On April 4, 2022, I received an *AFC Licensing Division – Incident/Accident Report* that was signed and dated by Administrator Emily Matuszak on April 4, 2022. What happened indicates that "Resident eloped out of the facility." Action taken by staff indicates "All staff in building searched every room. Door alarm was set off Resident went to parking lot. Staff retrieved resident." Corrective measures indicate "15-minute safety checks, inquiring about extra door alarms for safety measures."

On April 7, 2022, I telephoned Complainant 1. Complainant said she was driving west on Frankenmuth Road and saw Resident A on the side of the road on her hands and knees and was waving at her. Complainant 1 said Resident A did not have coat on. Complainant 1 stopped and got out to help her. Complainant 1 said Resident A was "confused, had no coat on, and was wearing only slippers on her feet." Resident A told Complainant 1 her name and assumed she was from Vassar Fields. Complainant 1 called the facility and asked if the Resident A lived there. The staff at the facility said 'yes' and that staff were out looking for her. Complainant 1 said she did not observe any staff out looking for her. Complainant 1 indicated it was about 35 degrees out and the time was between 9:30-9:45 am. Complainant 1 took her back to the facility.

On April 20, 2022, I conducted an onsite investigation and interviewed Administrator Emily Matuszak. Ms. Matuszak stated she was not working at the time, but staff notified her about Resident A leaving the facility. Ms. Matuszak indicated she reviewed the outside cameras and said "she (Resident A) was going very fast." Ms. Matuszak said Resident A "is very mobile and was going very fast." Resident A does not need a walking device. Ms. Matuszak said staff were out looking for her and then some lady brought her back.

On April 20, 2022, I interviewed Staff Ashley Rau at the onsite investigation. Ms. Rau said she was working that morning and she was in another resident's room and heard the alarm. Ms. Rau said it was the alarm on the west end of the building, so she knew what door she went out. Ms. Rau said she and other three staff went looking for her and left two staff in the building looking in closets and other rooms for her. Ms. Rau said she went down the hill behind the facility thinking she may have gone down it. Ms. Rau indicated one staff member left in their car to look for her. Ms. Rau said when Resident A left the facility, they thought she was headed east and the and that is the direction staff were looking for her. Resident A was found west of the facility. Ms. Rau said Resident A "wants to go to school" and if you stand up, she will also get up.

On April 20, 2022, I observed Resident A and she is in the later stages of dementia and unable to provide any information. Resident A appeared clean and well taken care of.

On April 27, 2022, I received a copy of Resident A's *Assessment Plan for AFC Residents* that was signed and dated on February 21, 2022, by Family Member 1 and License Diane Vondette. It indicates under 'Moves independently in Community' it is answered 'yes, within memory care unit.' The assessment plan does not indicate that Resident A has a history of eloping.

Administrator Matuszak indicated that Resident A used to be able to walk throughout the entire facility but since this incident, either a staff person or a family member must accompany her. Administrator Matuszak said this was agreed with Resident A's three family members.

On April 25, 2022, I telephoned Family Member 1. Family Member 1 stated there was a meeting with him, two other family members and Administrator Matuszak. Family Member 1 indicated the facility is going to put louder alarms on the doors and was going to check on a delayed lock. Family Member 1 said he was notified that day that Resident A had eloped from the facility. Family Member 1 stated "they were blessed that a responsible person brought her back to the facility" and she was not injured. Family 1 said the staff are caring and they all know that Resident A wants to leave the facility. Family Member 1 does not have any other concerns about the care Resident A receives in the facility.

On April 20, 2022, I conducted a face-to-face exit conference with Administrator Emily Matuszak, who has written permission from Licensee Diane Vondette to conduct licensing issues. Administrator Matuszak advised this is a rule violation because Resident A left the facility and was returned by a stranger.

APPLICABLE RULE	
R 400.15305	**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:	Complainant 1 found Resident A about ¼ mile away from the facility with a coat and only slippers on. It was about 35 degrees on that day. Staff Ashley Rau said Resident A left the facility out of the west side door.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective plan, I recommend the status of this adult foster care large group home remain unchanged (capacity 1-20).

04/27/2022

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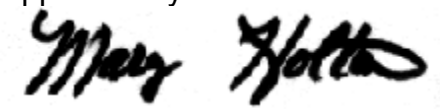
Kathryn A. Huber Date
Licensing Consultant

Approved By:



04/28/2022

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Mary E Holton Date
Area Manager