GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 30, 2022

Serenity Brain
Courtyard Manor of Wixom Inc
Suite 127
3275 Martin
Walled Lake, MI 48390

RE: License #: AL630007340
Investigation #: 2022A0465031
Courtyard Manor of Wixom III

Dear Ms. Brain:

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 (248) 975-5053.

Sincerely,

Stephanie Gonzalez, LCSW
Adult Foster Care Licensing Consultant
Bureau of Community and Health Systems
Department of Licensing and Regulatory Affairs
Cadillac Place, Ste 9-100
Detroit, MI 48202
Cell: 248-514-9391
Fax: 517-763-0204

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL630007340
Investigation #:	2022A0465031
Complaint Receipt Date:	05/09/2022
Investigation Initiation Date:	05/10/2022
Report Due Date:	07/08/2022
Licensee Name:	Courtyard Manor of Wixom Inc
Licensee Address:	Suite 127 - 3275 Martin Walled Lake, MI 48390
Licensee Telephone #:	(248) 926-2920
Administrator:	Serenity Brain
Licensee Designee:	Serenity Brain
Name of Facility:	Courtyard Manor of Wixom III
Facility Address:	48578 Pontiac Trail Wixom, MI 48393
Facility Telephone #:	(248) 669-5263
Original Issuance Date:	12/27/1991
License Status:	REGULAR
Effective Date:	08/20/2020
Expiration Date:	08/19/2022
Capacity:	20
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
On 5/5/2022, Resident A eloped from the facility due to there not being sufficient staff on duty to provide supervision.	Yes

III. METHODOLOGY

05/09/2022	Special Investigation Intake 2022A0465031
05/10/2022	Special Investigation Initiated - Telephone I spoke to licensee designee/administrator, Serenity Brain, who confirmed that Resident A was located and returned to the facility on 5/9/2022
05/20/2022	Inspection Completed On-site I reviewed Resident A's file, the employee schedule, interviewed direct care staff, Heather Gregory and interviewed Resident A
05/23/2022	Contact - Document Received Facility documents received via email
06/01/2022	Contact - Document Received Facility documents received
06/26/2022	Contact - Telephone call made I interviewed direct care staff, Andre Meeks, via telephone
06/26/2022	Contact - Telephone call made I interviewed licensee designee/administrator, Serenity Brain, via email
06/26/2022	Exit Conference I conducted an exit conference with Ms. Brain via telephone

ALLEGATION:

On 5/5/2022, Resident A eloped from the facility due to not being sufficient staff on duty to provide supervision.

INVESTIGATION:

On 5/9/2022, an *Incident/Accident Report* was received, indicating that on 5/5/2022, Resident A eloped from the facility. Resident A was last observed in the facility at 6:45am and was reported missing by direct care staff at 7:15am.

On 5/10/2022, I spoke to licensee designee/administrator, Serenity Brain, who confirmed that Resident A eloped from the facility on 5/5/2022 and was located by law enforcement and returned to the facility on 5/6/2022.

On 5/20/2022, I conducted an onsite investigation at the facility. At the time of my onsite investigation, there were 20 residents residing in the facility. I reviewed Resident A's file, the staff schedules, interviewed direct care staff, Heather Gregory, and interviewed Resident A.

I reviewed the *Staff Schedules* for the months of February 2022, March 2022, April 2022, and May 2022. According to the staff schedules, there are always two staff on duty at all times, and an average of 3-4 staff on duty during 2nd shift.

Resident A's *Face Sheet* stated that he was admitted to the facility on 12/13/2021 and has a legal guardian, Guardian A1. The *Health Care Appraisal* stated that Resident A's medical diagnosis is Schizophrenia. The *Assessment Plan for AFC Residents* stated that Resident A requires supervision in the community, has a history of suicidal ideation, elopements, confusion, hallucinations, and paranoia, requires minimal assistance with self-care tasks and does not require use of assistive devices. The *Incident/Accident Report*, dated 5/5/2022, stated the following:

5/5/2022 at 7:15am; Completed by Andre Meeks: Upon 7am rounds, Resident A was not observed in the building. Resident A was last observed at 6:45am by staff. Code Green called and area inside and outside the property was searched. 911 contacted and reported to the property. Employees began to search the area via vehicles to check local businesses. Description of resident given to police, and they took over the search.

The *Incident/Accident Report*, dated 5/6/2022, indicated the following:

> 5/6/2022 at 2:45pm; completed by Serenity Brain: Resident A was returned to the facility. Resident A was observed at the New Hudson, MI Walmart at approximately 2:45pm. Resident A ran when they called his name. Police were notified and with their help, Resident A was found at Taco Bell and taken into police custody. No apparent injury. It was determined that Resident A would be

petitioned out to the ER for evaluation and treatment. We explained everything to Resident A, and he was in agreement to go to the ER due to safety concerns.

I interviewed direct care staff, Heather Gregory. Ms. Gregory stated, “We always have a minimum of two staff on duty at all times, and often times three staff on duty when needed. Our facility has a keypad entry with a 20 second delay. We have a perimeter alarm system as well that alerts staff if a resident attempts to leave the property. We also do 30-minute checks on all residents. But Resident A was on 15-minute checks. Resident A has a history of elopement at other facilities prior to coming here. This is Resident A’s first elopement from our facility. He snuck out of his bedroom window.” Ms. Gregory did not provide additional information as to how Resident A was able to elope from the facility without the perimeter alarm notifying direct care staff.

I interviewed Resident A while onsite at the facility. Resident A stated, “I did leave the facility. But it was a misunderstanding. I left out the window a little before 7am and I walked to the store. Then I took a bus to a nearby town. I slept outside. I came back the next day. It was a mistake. I won’t do it again.” Resident A acknowledged that he eloped from the facility on 5/5/2022 without staff knowledge.

On 6/26/2022, I interviewed direct care staff, Andre Meeks, who reported that he has been working at the facility for twenty years. Mr. Meeks stated that he was working at the time that Resident A eloped from the facility. Mr. Meeks stated, “Prior to 5/5/2022, Resident A never eloped before from our facility but has a history of elopement from other facilities prior to coming here. On the morning of 5/5/2022 around 7:15am, we noticed during rounds that Resident A was gone. I went to Resident A’s room and observed his window closed with the screen missing. We did a Code Green and called 911. We have a perimeter alarm that is like a beam or laser, that covers the entire area of the facility. The perimeter alarm goes off if someone walks around the exterior of the facility. The alarm alerts staff that someone is outside on the premises. However, on Mondays, we have a lawn care company, and we deactivate the perimeter alarm system. And sometimes we forget to turn it back on after they are done. And the perimeter alarm sometimes isn’t re-activated until Tuesdays when we remember to manually turn it back on. Also, sometimes we manually deactivate the perimeter alarm on other days of the week when the alarm keeps going off due to birds flying by and activating the alarm to continually go off. Every Monday during the warm season, the perimeter alarm is de-activated the entire day.”

On 6/26/2022, I interviewed licensee designee/administrator, Serenity Brain. Ms. Brain stated, “Resident A does have a history of elopement at prior facilities, but he never eloped from our facility prior to 5/5/2022. We have a photoelectric alarm that monitors the windows outside of resident bedrooms. It is in place to alter staff if a screen is popped out. However, on the day that Resident A eloped, the perimeter alarm was turned off. I cannot tell you that time it was turned off. For those few days it was going off consistently due to a bird’s nest as well as lawn maintenance. The staff conducted 15-minute checks on Resident A, and he was last seen by staff at 6:45am and was observed missing from the facility at 7:00am. Resident A was found by direct care staff

the following day (5/6/2022) and returned to the facility by law enforcement at 2:30pm. Resident A has not eloped since this time."

On 6/27/2022, I conducted an exit conference with Ms. Brain. Ms. Brain is in agreement with the findings of this report as it relates to the established rule violation.

APPLICABLE RULE	
R 400.15206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	According to the *Staff Schedules*, the facility has a minimum of two staff on duty at all times, during 1st and 3rd shift, and a minimum of three staff on duty during 2nd shift. According to Ms. Gregory, Mr. Meeks, Ms. Brain and the *Assessment Plan for AFC Residents*, Resident A has a history of elopement. Resident A acknowledged that he eloped from the facility on 5/5/2022 without staff knowledge. According to Mr. Meeks and Ms. Brain, on 5/5/2022, the facility's photoelectric alarm system was turned off. During the time that the alarm system was disabled, Resident A was able to elope from the facility through his bedroom window without staff being alerted. Ms. Brain acknowledged that additional safety measures nor increased supervision was implemented for Resident A during the time that the alarm system was disabled. Mr. Meeks and Ms. Brain stated that it is common for the perimeter alarm system to be manually disabled at least once per week. Subsequently, Resident A's whereabouts were unknown from 5/5/2022 at 7:00am through 5/6/2022 at 2:45pm, approximately 19 hours. Based on the information above, the facility did not have sufficient staff on duty to provide supervision and protection to Resident A during the time that the perimeter alarm system was disabled.
CONCLUSION:	**VIOLATION ESTABLISHED**

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:	According to Ms. Gregory, Mr. Meeks, Ms. Brain and the *Assessment Plan for AFC Residents*, Resident A has a history of elopement. Resident A acknowledged that he eloped from the facility on 5/5/2022 without staff knowledge. Subsequently, Resident A's whereabouts were unknown from 5/5/2022 at 7:00am through 5/6/2022 at 2:45pm, approximately 19 hours. During this time, Resident A was unsupervised, and his personal needs, including protection and safety were not attended to.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Stephanie Gonzalez

6/28/2022

Stephanie Gonzalez — Date
Licensing Consultant

Approved By:

Denise Y. Nunn

06/30/2022

Denise Y. Nunn — Date
Area Manager