GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 9, 2022

Katrina Aleck
AH Kentwood Subtenant LLC
6755 Telegraph Road Suite
Bloomfield Hills, MI 48301

RE: License #:	AL410397693
Investigation #:	2022A0356027
	AHSL Kentwood Cobblestone

Dear Ms. Aleck:

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

Sincerely,

Elizabeth Elliott, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 901-0585

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL410397693
Investigation #:	2022A0356027
Complaint Receipt Date:	06/06/2022
Investigation Initiation Date:	06/06/2022
Report Due Date:	08/05/2022
Licensee Name:	AH Kentwood Subtenant LLC
Licensee Address:	One SeaGate, Suite 1500 Toledo, OH 43604
Licensee Telephone #:	(248) 203-1800
Administrator:	Tami McKellar
Licensee Designee:	Tami McKellar
Name of Facility:	AHSL Kentwood Cobblestone
Facility Address:	5960 Eastern Ave SE. Kentwood, MI 49508
Facility Telephone #:	(616) 455-1357
Original Issuance Date:	01/18/2019
License Status:	REGULAR
Effective Date:	07/18/2021
Expiration Date:	07/17/2023
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED

II. ALLEGATION(S)

	Violation Established?
Resident A did not receive adequate supervision and protection at the facility.	Yes

III. METHODOLOGY

06/06/2022	Special Investigation Intake 2022A0356027
06/06/2022	Special Investigation Initiated - Telephone Katrina Aleck, regional nurse, clinical specialist, and acting Licensee Designee.
06/06/2022	Contact - Document Received Area Manager Jerry Hendrick and Licensing consultant Anthony Mullins.
06/07/2022	Contact - Telephone call made Kindred Hospice-Casey Nicholas.
06/09/2022	Inspection Completed On-site
06/09/2022	Contact - Face to Face Jennifer Schuchard, regional wellness director, Kayla Meek, VP Resident Care, Laura Kelling, Exec. director, Am. House Wyoming, support, Katrina Aleck, Clinical specialist, support. Staff Tatiana Lopez.
06/09/2022	Contact-Documents received Facility documents received.
06/14/2022	Contact - Telephone call made Cynthia Torres, Direct Care Worker.
06/14/2022	Contact - Telephone call made DCW Amanda Larriuz, left voicemail mess.
06/14/2022	Contact - Telephone call made Relative #1
06/14/2022	Contact - Telephone call made Cynthia Torres, staff.
06/15/2022	Contact - Telephone call received

	Relative #1
06/16/2022	Contact - Telephone call received Relative #2
06/28/2022	Contact - Document Received BCAL complaint received.
07/18/2022	Contact - Document Received Kentwood Police Report.
07/20/2022	Contact - Telephone call made Tatiana Lopez, staff. Katrina Aleck, clinical specialist.
07/25/2022	Contact-Telephone call made Staff, Amanda Larriuz, left voicemail message. No return call since 06/14/2022. Cynthia Torres, DCW.
07/28/2022	Contact-Document Sent Email to Ms. Aleck requesting DCW Amanda Larriuz return my call.
08/03/2022	Contact-Telephone call made DCW Amanda Larriuz-left message on voicemail. Still, no return telephone call from Ms. Larriuz.
08/05/2022	Exit Conference Licensee Designee (stand in) Katrina Aleck.

ALLEGATION: Resident A did not receive adequate supervision and protection at the facility.

INVESTIGATION: On 06/06/2022, I opened a BCAL (Bureau of Children and Adult Licensing) Complaint stemming from a Fox News story, (https://www.fox17online.com/news/local-news) dated 06/03/2022 at 4:21p.m. The news story documented the following information, *'An elderly Kentwood resident has died in an accidental drowning Thursday night. The Kentwood Police Department says it happened near Eastern Avenue and 59th Street after 10p.m. The victim is described as an 86-year-old resident of a nearby elderly care facility. We're told she died on the scene. The drowning is currently being investigated.'* The article shows a picture of the facility at night from the outside.

On 06/06/2022, I interviewed Katrina Aleck, Regional Nurse and stand-in Licensee Designee since the previous Licensee Designee, Tami McKellar resigned. Ms. Aleck stated the incident occurred on the evening of 06/02/2022 at about 10:00p.m.

outside of the American House Cobblestone facility. Ms. McKellar stated this facility is not a secured memory care facility and described it as an “assisted living community”, which does not have residents that require a memory care facility. Ms. Aleck stated the front door of the facility is locked to those who try to enter but does not prevent the residents from exiting the building and since this incident, an alarm has been installed to the front door. Ms. Aleck stated staff check on the residents every two hours and on the evening of 06/02/2022, staff reported at 8:00p.m., staff assisted Resident A to bed in her room. Staff reportedly checked on Resident A at 9:57p.m. and she was no longer in her room. Ms. Aleck stated staff observed Resident A to be missing from her room at 9:57p.m.. Staff looked for Resident A and discovered her in the pond outside the facility and called 9-1-1 at 10:11p.m. Ms. Aleck reported Resident A had been receiving Hospice services, ambulated independently, was not “exit seeking” or known to be an “elopement risk” prior to this incident. Ms. Aleck stated Resident A visited with family on the day of the incident, and according to information from staff, Resident A spoke about her deceased husband.

On 06/06/2022, I received and reviewed the Incident Report (IR) from Licensing Consultant, Anthony Mullins. The IR is dated 06/02/2022, 9:57p.m. The IR documented, *‘other person(s) involved/Witnesses’ as Amanda Larriuz, Tatiana Lopez, and Cynthia Torres.’* The IR documented Ms. Torres as the employee assigned to Resident A and the location of the incident as the community pond located behind the building. The IR documented the following information, *‘upon performing rounds, Cynthia observed (Resident A) was not in her apt. A quick search indicated (Resident A) was not inside community building. Cynthia searched grounds and observed (Resident A) face down in pond located behind community bldg.. at 10p.m., (Resident A) was observed to be non-responsive and was unable to be secured. 911 call placed with arrival time of 10:11p.m. Due to the terrain and depth of water. Firefighters on scene retrieved (Resident A) from pond. EMS declared (Resident A) deceased on arrival/DNR in place. Medical examiner arrival 11:45p.m. and transport 12a.m. (Relative #1)/DPOA on site. Pond drained 6/3/22 at 11a.m., alarm purchased and installed for front door to be activated for after hours. Flood lights for premises/doors and awaiting electrician to install.’* The IR was signed by Katrina Aleck, clinical specialist and Yovan Luyt on 06/03/2022.

On 06/06/2022, I received and reviewed a written statement of events from Mr. Mullins, written and signed by DCW (Direct Care Worker) Cynthia Torres. The document is not dated. Ms. Torres’ documented the following information: *‘I (Cynthia Torres) was doing my normal rounds @ 9:57p.m. when I realize that (Resident A) was not in her room. I notice her cat on her bed and her walker in her living room with all the lights on. I immediately called last staff member (*Amanda Larriuz*) to ask if (*Resident A*) was put in bed after dinner around 5:30p.m. she said yes! I said (*Resident A*) was not in her room or bed. But (*Amanda Larriuz*) did her check up rounds @ 8p.m. and that was the last time seen. I (*Cynthia Torres*) immediately, also called my supervisor (*Tatiana Lopez*) she suggested to look in every room and bathroom which she was not found. I also walked around the parking lot and the*

*center pavilion hoping to find her in one of those places but unfortunately she was not there. I thought to look in the pond and sadly I found her @10:04p.m. face down in the pond. I quickly called 911 @ 10:04p.m. and EMS arrived approximately @10:11p.m. I also called family at 10:16p.m., Hospice nurse "MiMi" @ 10:10p.m., I tried to act as quickly as possible and acted within 15 mins. But unluckily it was too late and (*Resident A*) was deceased when EMS arrived.'*

On 06/07/2022, I interviewed Casey Nichols, Kindred Hospice. Mr. Nichols stated Resident A was diagnosed with vascular dementia and described her as "not a wanderer" and that Resident A had not previously sought to elope from the facility. Mr. Nichols stated Resident A rarely got out of her chair, she did not wander or walk well and was "not cognitively able to make the decision to get up and go like she did." Mr. Nichols stated they cannot figure out how or why this incident happened.

On 06/09/2022, I conducted an unannounced inspection at the facility. I interviewed Katrina Aleck, nurse, clinical specialist and acting Licensee Designee, Laura Kelling, Executive Director, Kayla Meek, Vice President of Resident Care and Jennifer Schuchard, Regional Wellness Director in the main office on the campus of the facility. This campus has three AFC facilities on the grounds. Ms. Aleck stated Resident A moved into the facility on 07/06/2021 and has been a resident of this building, Cobblestone the entire time. Ms. Aleck stated on 06/02/2022, Resident A woke up, dressed, ate breakfast, visited with Relative #2 at some point during the day, Resident A had lunch, activities, dinner and went to bed. Ms. Aleck stated it was a typical day for Resident A. Staff Amanda Larriuz saw Resident A sleeping in her bed at 8:00p.m. on 06/02/2022, and at 9:57p.m., staff Cynthia Torres noticed lights were on in Resident A's room and went to check on her and discovered she was not in her room. Ms. Aleck stated Ms. Torres called Ms. Larriuz and asked if she had seen Resident A in her room at the earlier room check and Ms. Larriuz said she had seen Resident A in her bed. Ms. Aleck stated Ms. Torres began looking for Resident A and at 10:04p.m., Ms. Torres discovered Resident A in the pond outside of the facility, at 10:11p.m. EMS (emergency medical services) arrived with police and at 11:45p.m. the coroner arrived. Ms. Aleck stated Relative #1 was called and arrived on scene while EMS was there. Ms. Aleck stated Resident A did not have a history of elopement from the facility and has a dementia/Alzheimer's diagnosis, late onset. Ms. Aleck stated despite the dementia diagnosis, Resident A required general monitoring, she did not require a higher level of supervision as she did not exit seek. Ms. Aleck stated Resident A had never left the facility and never attempted to exit the building without staff or family supervision prior to this incident. Ms. Kelling, Ms. Meek, and Ms. Schuchard supported the information provided by Ms. Aleck.

On 06/09/2022, I interviewed DCW Tatiana Lopez at the Cobblestone building in an office across from where other staff were in a staff room/office. Ms. Lopez stated she has worked in this building for the past 17 years; Cynthia Torres has worked in the building for 5 years and Amanda Larriuz for 7 years. Ms. Lopez stated she worked 1st shift on 06/02/2022 (6:30a.m.-3:00p.m.) and described Resident A as her "typical self" prior to the accident. Ms. Lopez stated she assisted Resident A with getting

dressed around 6:30-7:30a.m., Resident A walked to breakfast in the main dining room at the facility, she ate “normally” and went back to her room. Ms. Lopez stated Resident A “likes to stay in her room with her cat Samantha,” she came down for dinner, watched TV, Ms. Larriuz assisted Resident A with toileting and evening care at 6:45p.m., Resident A went to bed assisted by Ms. Larriuz, Ms. Larriuz checked on Resident A at 8:00p.m. and she was in bed. Ms. Lopez stated Resident A was not exit seeking and had not previously attempted to elope from the facility. Ms. Lopez stated 90% of the time, Resident A wanted to stay in her room, in her bed with her cat, once a week she would come out of her room and go to the common area, but staff always got Resident A up, cleaned her up and got her down to meals because she would not do that on her own. Ms. Lopez stated Resident A usually did not talk much. She would ask for things but if you engaged her in talk, she would talk. Ms. Lopez stated earlier in the day on 06/02/2022, Relative #2 came to visit Resident A after lunch, they sat in the main living room in the facility. Ms. Lopez stated sometimes they would sit out by the fountain but on this date, they stayed in the facility in the living room. Ms. Lopez stated Ms. Larriuz checked on Resident A at 8:00p.m. and she was in bed, at 9:57p.m. she (Ms. Lopez) received a telephone call from Ms. Torres that Resident A was not in her room, Ms. Lopez stated she instructed Ms. Torres to go room to room and check all bathrooms. Ms. Lopez stated at 10:04p.m., Ms. Torres called her and told her she had found Resident A in the pond. Ms. Lopez stated Ms. Torres called 9-1-1 immediately, family and hospice.

On 06/09/2022, I received and reviewed facility documents for Resident A.

- Resident A’s healthcare appraisal dated 08/09/202, signed by Dr. Bahram Elami. The health care appraisal documented that Resident has ‘*memory loss, diminished memory.’*
- With the healthcare appraisal is a report from Metro Health-University of Michigan health dated 04/30/2021 and signed by David Nyenhuis, PhD, Licensed Clinical Psychologist referred to by Dr. D. Albrecht, DO. Dr. Nyenhuis’ diagnosis is documented as ‘*Late onset Alzheimer’s Dementia without behavioral disturbance, other specified depressive episodes.*’ The report documents, ‘(Resident A) *demonstrated a lack of understanding and appreciation of her general cognitive and memory deficits. She also showed diminished ability to determine risks and benefits of her decisions. For these reasons,* (Resident A) *is no longer capable of making reasonable decisions and a surrogate decision maker should be selected to make decisions that are in her best interest. This is a permanent condition.* (Resident A) *denies depression or anxiety symptoms but* (Relative #2) *reports some mild day to day disturbances. If this continues consider antidepressant medication. Unfortunately, continued cognitive and functions decline are likely and (*Resident A*) will likely require increasingly greater care and assistance. Family members should continue to discuss plans on how to best meet this challenge.’*
- Resident A’s assessment plan dated 03/25/2022 completed by Katrina Aleck documented Resident A’s ability to move independently in the community as ‘*yes*.’ There is no other information or explanation in this category. This

document is not signed by Resident A, Resident Care Director/Nurse, Family/Responsible Party, or the Licensee Designee/Executive Director.

- Another document titled '*Change of Condition'* assessment is dated 09/20/2021 completed by Tatiana Lopez was reviewed and this document has Resident A's ability to move independently in the community under a heading, '*Resident Security*,' and explains, '*Only leave community on outings with staff, family, or a friend. Unsafe to leave unescorted but has no history of attempting to leave unescorted.'* This document showed Resident A's *'use of assistive devices as hearing aids, cane and wheeled walker.'* This document is signed by Ms. Lopez on 09/20/2021 & 10/13/2021, Relative #1 signed the document on 10/13/2021.

On 06/09/2022, I received and reviewed a written statement of events, type written, not dated with DCW Amanda Larriuz's name. The statement documented the following information: *'I Amanda Larriuz, walked (Resident A) back to her room using her 4 wheeled walker and helped her sit on the couch so she could watch tv until it was time to help her get ready for bed. I came back to her room roughly around 6:45, to help (Resident A) use the toilet and get washed up for bed. Once she was in bed, I tucked her in, sat her cat next to her and set her walker beside the bed just in case she wanted to get up for any reason. At 8p.m. I did my routine rounds and saw (Resident A) was sleeping peacefully in bed. I left work around 9:30p.m.'*

On 06/14/2022, I interviewed Ms. Torres via telephone. Ms. Torres confirmed the information provided in her written statement as true and factual information. Ms. Torres stated she and Ms. Larriuz worked together up until approximately 10-15 minutes before she went in to check on Resident A at 9:57p.m. Ms. Torres stated Ms. Larriuz left the facility at approximately 9:30p.m. so she (Ms. Torres) was the only staff in the building at the time as 3rd shift comes in at 11:00p.m. Ms. Torres stated she conducted rounds every 2 hours and checked on every resident to make sure they were in bed and everything was ok, they had not fallen or needed anything. Ms. Torres stated the residents in this building are mainly independent and none require a two-person assist or the assistance of a Hoyer lift. Ms. Torres stated Resident A did not go outside much, she would sit on chairs outside the front door but other than that, she did not walk around much. Ms. Torres stated Resident A was not exit seeking, she did not try to leave or elope from the building. Ms. Torres stated Resident A had dinner at 5:00p.m., Ms. Larriuz assisted her with getting pajamas on at 5:45p.m. and at 8:00p.m., Resident A was observed by Ms. Larriuz in her room, sleeping in her bed. Ms. Torres stated she assisted other residents and at 9:30p.m. she went into the office where Ms. Larriuz was charting, and they finished Ms. Larriuz's shift, which ended at 9:30p.m., charting in the office. Ms. Torres stated at approximately 9:45p.m. she left the office and went to check on the residents and that is when she discovered Resident A was not in her room. Ms. Torres stated Resident A must have gone out the front/main door of the facility because all the other doors are locked and have alarms on them. The front door does not have an alarm. Ms. Torres stated she usually locks the front door after Ms. Larriuz leaves her shift and she did so on 06/02/2022, after Ms. Larriuz left, at 9:30p.m. Ms. Torres

stated Resident A must have already been out of the building. Ms. Torres stated the building has five doors in total and all are locked with alarms on them, but the doors are locked to people coming in from the outside, residents can exit from the inside, and that will trigger an alarm notifying staff, but Ms. Torres stated she did not hear a door alarm that night. The main/front door did not have an alarm installed until after this incident.

On 06/14/2022, I interviewed Relative #1 via telephone. Relative #1 stated he received a telephone call from staff at 10:30p.m. on 06/02/2022 informing him of Resident A's death. Staff reportedly informed him that Resident A had been in the building at 8:00p.m. and not there at 10:00p.m. Relative #1 stated there was not an alarm on the front door but the front door is hard to push open so due to Resident A's small stature and instability, he does not think that was the door Resident A exited out of the building. Relative #1 stated he thinks Resident A went out the side door and the alarm was not working as staff have to turn that alarm on and off and typically turn it off during the day, on at night. Relative #1 stated that initially Resident A loved to walk and when she first arrived at this facility, she would take walks but as time went by, she walked less frequently. Relative #1 stated Resident A does not have a history of wandering or exit seeking however, she has gone out to the parking lot of the facility, but not recently. Relative #1 stated generally Resident A used a walker and slowly, in a shuffling way walked and got around mostly, assisted by staff. Relative #1 stated, when Resident A first moved into the facility in 2021, she walked much better and would walk daily. Relative #1 stated Resident A went outside to walk on occasion and staff would inform Relative #1 & #2 when Resident A went outside and walked. Relative #1 stated there were times that Resident A would say things like, "I'm tired of this, I'm going to get out of here" but she had no history of elopement or exit seeking from this facility. Relative #1 stated Relative #2 went to visit Resident A on the date of her death and "she was having a bad day." Relative #1 stated Relative #2 told staff that Resident A's "mind was bad that day" and she was "hallucinating."

On 06/16/2022, I interviewed Relative #2 via telephone. Relative #2 stated she believes Resident A went out the door off the main living/dining room because the alarm on that door did not work as it never went off when she and Resident A went out to sit on the porch during previous visits. Relative #2 stated Resident A changed a lot in the first 11 months of being at this facility and now, her mobility was quite diminished. Relative #2 stated Resident A was not able to move about very well especially without a walker. Relative #2 stated last fall, Resident A walked outside the facility and staff told Resident A that she needed to stay inside the building. Then, in October 2021, Relative #2 stated she and Relative #1 met with Ms. Lopez and Tami McKellar, former Licensee Designee to discuss an increase Resident A's care. Relative #2 stated a move to memory care was discussed, but Ms. Lopez and Ms. McKellar stated they did not think Resident A needed memory care yet and assured Relative #1 & #2 that staff at this facility could take care of Resident A in the current building she was in. Relative #2 stated the pond is just off the living/dining room door past the porch area that she and Resident A would sit and visit on often.

Relative #2 stated on 06/02/2022, she found Resident A in the main dining/living area of the facility, which was unusual because she was usually in her room. Relative #2 stated Resident A was by herself, sitting in a chair, with her walker near her. Relative #2 stated she does not know how she got there, if she ambulated there herself or if staff assisted her there, but they stayed in the main dining/living area for their visit on 06/02/2022. Relative #2 stated Resident A was legally blind and had peripheral vision only so she sat close to Resident A in a spot that she could see her. Relative #2 stated Resident A was talking about things that did not make sense. Resident A asked Relative #2 what her (Relative #2's) name was and what her own name was, and she had never asked that before. Relative #2 stated she thought Resident A was hallucinating because she (Resident A) said she could see people, namely her deceased mother and husband. Relative #2 stated Resident A talked about her mother and how she (Resident A) told her mother that she had to take care of her (Resident A's) husband (who is deceased). Relative #2 stated Resident A kept trying to get a nonexistent object into her pocket so Relative #2 stated she assisted Resident A in getting her hand in her pocket and that seemed to satisfy Resident A at that time. Relative #2 stated she then tried to get Resident A "back to reality." Relative #2 stated she located Ms. Lopez and another (unknown) staff in the nurse's room and spoke to Ms. Lopez and informed her that "mom is having an exceptionally bad day" and explained what she had seen with Resident A. Relative #2 stated Ms. Lopez said Resident A "has good days and bad days" and Relative #2 stated she felt as though staff "blew her off." Relative #2 stated she went back to Resident A who stated she needed to use the bathroom so she (Relative #2) asked Ms. Lopez to assist Resident A. Relative #2 stated Ms. Lopez assured her that she would get Resident A back to her room and assist her with toileting. Relative #2 stated she had visited with Resident A for an hour, so she left. Relative #2 stated she felt as though she was not being listened to that day and that she was "shut down" by Ms. Lopez right away when she told Ms. Lopez that Resident A was having an "exceptionally bad day." Relative #2 stated she was concerned leaving Resident A that day because she left her alone in the living/dining room and both staff were in a room down the hall. Relative #2 stated Resident A's shoe was found stuck in the rocks outside the pond on the evening of her death, Relative #2 surmised that Resident A got up and put her shoes on and for Resident A to get from her room to the pond with as slow as her ambulation was and without her walker, had to have taken a very long time.

On 06/28/2022, I received a BCAL (Bureau of Children and Adult Licensing) Online complaint. The complainant reported Resident A's care, safety and wellbeing were entrusted to the healthcare professionals and staff members at American House Cobblestone. The complainant reported Resident A had progressive issues with impaired memory and dementia, she relied on the use of a walker for assistance with ambulation, she was legally blind due to macular degeneration, and she had recent bouts of hallucinations which were brought to the attention of Ms. Lopez on the same day as her fatal drowning. The complainant reported American staff should not have allowed Resident A to leave the building at night unsupervised. The doors exiting the building were unlocked to residents that night and the alarms on these

doors were either inoperable or disengaged. The complainant reported Resident A was confused and was able to make her way with no visual detection from staff through the side or front door of the facility and on to the grounds surrounding the facility. The complainant reported it is unlikely that Resident A could have ambulated out the front door without a walker over the unlevel terrain and lengthy distance, through grass, wooden paths, and concrete surfaces leading to the pond on her own. In addition, the complainant reported, Relative #3 went to the facility on 06/03/2022 in an attempt to understand what had happened to Resident A and while there, observed a man from Riverside Integrated Systems on a ladder working on the side door of the facility and/or the door alarm. The complainant reported Relative #3 overheard the repairman say, “I just got the side door alarm working again.” The complainant reported this side door, exiting the dining area that Resident A frequented, was close in proximity to both Resident A’s room and the pond. The complainant reported, despite the exit door used, Resident A should have never been allowed to roam outside, alone at night, unsupervised near the foreseeably dangerous, unprotected steep rocky bank and pond, under any circumstances.

On 07/18/2022, I received and reviewed the Kentwood Police Report, Case 2022-00009507, written by Officer Miller, Kentwood police department on 06/02/2022. Officer Miller documented the event was reported on ‘*06/02/2022 at 10:11p.m., the event occurred on 06/02/2022 at 22:11 (10:11p.m.), occurred incident type, death-natural. DOA-Suspicious Conditions, 06/02/2022, 22:05 (10:05p.m.).’*

‘*Information: On the above date and time I responded to 5960 Eastern, Cobblestone Manor, in regard to a subject who was found unresponsive in a pond. Cobblestone Manor is an assisted living home, and the unresponsive subject was an 86-year-old resident. Kentwood Fire attempted life saving measure, but the patient was pronounced deceased at 22:24 hours. The medical examiner arrived on scene, took photographs, and will be conducting an autopsy.’*

‘Kentwood Fire: I arrived on scene to find Kentwood Fire Engine 53 with the patient. They advised that they found her lying face down in the pond. They stated that she was cold to the touch but not in rigor. Fire performed life saving measures until they were informed by Cobblestone Manor employees that the patient had a Do Not Resuscitate Order. Life saving measures were then stopped.’

*‘AMR (*American Medical Response*) 122 arrived on scene and contacted Dr. Anderson from Metro Hospital, who pronounced the time of death at 22:24 hours (*10:24p.m.).’

‘(Resident A) (Deceased) was born 09/14/1935, Diagnosis- (Resident A) has been diagnosed with late onset Alzheimer’s Dementia, non-Hodgkin’s lymphoma, colon cancer-subtotal colectomy, hypothyroidism, osteopenia, hemorrhoids, Rheumatoid Arthritis, and Hypogammaglobulinemia. (Resident A) struggles to walk on her own and generally requires the assistance of a walker. However, (Resident A’s) walker was located inside of her room and not outside near the pond. (Resident A’s) family

and Cobblestone Manor staff advised that they were very surprised that (Resident A) was able to walk out of the building without her walker.'

'Contact with Cynthia Torres (witness): Cynthia is a nurse at Cobblestone Manor and advised that she had last seen (Resident A) after dinner around 17:00 hours (5:00p.m.) in her room. Cynthia stated that normally (Resident A) will get back from dinner, change into her pajamas, and go to bed. Cynthia advised that she was checking on all the residents at 22:00 (10:00p.m.) hours to make sure they were all in bed when she noticed that (Resident A) was missing. Cynthia stated that at 22:05 (10:05p.m.) she found (Resident A) facedown and unresponsive in the pond on the South side of the building. Cynthia advised that the building that (Resident A) lives in is not a lock down facility and the residents are allowed to walk in and out of the building without direct supervision. However, (Resident A's) ability to walk has severely declined and it has been a year since she has taken a walk around the building. Cynthia stated that she found (Resident A's) walker inside of her room, so she was very surprised that she was able to walk as far as she did, Cynthia also advised that (Resident A) had not been acting normally today. Cynthia stated that (Resident A) seemed "out of it" and appeared to be having some sort of hallucinations throughout the day.'

*'Scene Description: There is a side door on the South side of the building that leads directly to the pond that (*Resident A*) was found in. However, Cynthia said that an alarm would sound if that door was opened, and the alarm never triggered. Cynthia advised that (*Resident A*) must have walked out of her room, out the building's front door on the West side of the building, then walked around to the South side of the building and fell into the pond. The pond appeared to be approximately 4-5 feet deep.'*

Officer Garret Tremaine, Kentwood police department added a case supplemental report to Officer Miller's original report on 06/02/2022. Officer Tremaine's report documented the following information*: 'Contact with (Relative #1). (Relative #1) advised that (Resident A) has been living in this assisted living facility since June of 2021. He advised that (Resident A) had been diagnosed with Dementia. He advised that she would have moments where she was very confused, but these moments would last a few hours at a time.'*

*'Contact with witness, (*Relative #2*): (*Relative #2*) advised that she visited (*Resident A*) earlier today. (*Relative #2*) said that (*Resident A*) seemed to be very disoriented during her visit. She said that it was expected that (*Resident A*) would pass fairly soon, but she never would have expected (*Resident A*) to pass by falling into the pond on the property.'*

On 06/06/2022, the case was assigned to Detective Dascenzo, Kentwood Police Department. The supplemental report documented the following information: *'I went to the scene and spoke with manager Stacy Davidson regarding this matter. She confirmed that there were neither interior or exterior camera on the building. I*

checked the surrounding homes and found no cameras that would have captured this incident. I also confirmed there were no door alarms that would have been triggered. On 06/15/22, I contact the Medical Examiner's Office. The full report is still pending; however, I was advised that Dr. Stephen Cohle had completed the autopsy and had ruled the following: Accidental, manner of death: Asphyxia by drowning.'

On 07/20/2022, I interviewed Ms. Lopez again and Ms. Lopez stated it was not until after Resident A's death that Relative #2 said that Resident A was talking about her deceased husband, that was the first she (Ms. Lopez) had heard of it and understands Relative #2 stated that after Resident A's death to other staff at the scene. Ms. Lopez stated Resident A did not "seem off" on the day of her death, it was "a normal day for her." Ms. Lopez stated she does not recall Relative #2 telling her she thought Resident A was hallucinating or telling Relative #2 that Resident A "has good days and bad days." Ms. Lopez stated increased supervision was not ordered because Resident A was "not acting out of her norm" on the date of her death.

On 07/25/22, I interviewed Ms. Torres again and Ms. Torres stated, "yes, (Resident A) was off that day," and that she observed Resident A sitting in the dining room by the TV "staring up at the ceiling, not saying anything at all." Ms. Torres stated she observed Resident A "reaching up to the ceiling like she was reaching for something." Ms. Torres stated Resident A "didn't seem herself that day." Ms. Torres stated she went into the nursing room on 06/02/2022 and was with Ms. Lopez when Relative #2 came in and told Ms. Lopez that Resident A seemed off and was hallucinating, that she was "not right" and that she was "concerned about her." Ms. Torres stated she does not remember Ms. Lopez saying anything or responding. Ms. Torres stated Relative #2 was talking to Ms. Lopez directly and that she (Ms. Torres) had just stopped into the nursing room. Ms. Lopez stated increased supervision of Resident A was not ordered but staff continued with two-hour checks the rest of the day.

On 08/05/2022, An Exit Conference was conducted with (stand in) Licensee Designee, Katrina Aleck via telephone. Ms. Aleck stated a thorough corrective action plan detailing all corrective measures taken and planned will be submitted.

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:	Resident A drowned in a pond outside of the building she resided in at the facility.

	Ms. Aleck, Ms. Larriuz, Ms. Lopez, and Ms. Torres stated Resident A was checked on every two hours and she was observed in bed at 8:00p.m., missing at 9:57p.m. and discovered unresponsive in the pond at 10:00p.m. All staff reported that Resident A did not have a history of exit seeking, elopement, wandering away or attempting to elope from the facility. All staff reported that Resident A required the use of a walker, was not agile and did not ambulate steadily or swiftly without staff assistance. The Incident Report dated 06/02/2022 depicts the same information as reported by Ms. Aleck, Ms. Larriuz, Ms. Lopez, and Ms. Torres. Mr. Nichols stated Resident A rarely got out of her chair and did not wander or walk well. Ms. Aleck stated Resident A had no history of elopement. Resident A required general monitoring and did not require a higher level of supervision as she did not exit seek. Ms. Aleck stated Resident A has never left the facility and never attempted to exit the building without staff or family supervision. Ms. Kelling, Ms. Meek, and Ms. Schuchard supported the information provided by Ms. Aleck. Ms. Torres stated Relative #2 approached Ms. Lopez and reported Resident A was having a bad day with hallucinations on 06/02/2022. Ms. Torres stated she witnessed Resident A reaching up toward the ceiling and it appeared as though she was hallucinating on the day of her death. Ms. Torres and Ms. Lopez stated an increase in Resident A's supervision was not made on 06/02/2022 but continued two-hour checks were made the rest of the day. Ms. Lopez stated Resident A did not act out of the ordinary on the day of her death and does not recall anyone including Relative #2 telling her Resident A was hallucinating and having a bad day. Ms. Aleck stated staff reported Resident A was talking about her deceased husband on 06/02/2022. Resident A's healthcare appraisal documents Alzheimer's dementia as a diagnosis and that Resident A showed a

	diminished ability to determine risks and benefits of her decisions. Resident A's assessment plan documented Resident A's ability to move independently in the community, however, the biannual review, all dated the same date of 03/25/2022, documented that Resident A can only leave the community on outings with staff, family, or a friend. It noted no history of attempting to leave unescorted. Relative #2 reported Resident A was not acting as she normally does on the day of her death. She was hallucinating and seemed "off." Relative #2 stated she notified Ms. Lopez while Ms. Torres was present but Relative #2's concerns seemed to be dismissed. The Kentwood Police Report documented Resident A's death occurred on 06/02/2022 due to an accidental drowning in the facility pond. The police report documented the full autopsy report was not available, but Dr. Stephen Cohle completed the autopsy and ruled the following: Accidental, manner of death: Asphyxia by drowning. There is a preponderance of evidence to show that on 06/02/2022, Resident A was experiencing hallucinations, confusion and was not acting herself as reported by Relative #2. Relative #2 reported she informed Ms. Lopez and Ms. Torres about these concerning behaviors. Based on investigative findings, despite the fact that Resident A did not have a history of elopement or wandering away from the facility in the past, on the evening of 06/02/2022 between 8:00p.m. and 9:57p.m., Resident A was able to walk out of the facility unnoticed and made it to the facility pond where she fell in and drowned. Staff failed to provide the level of supervision and protection that Resident A required on 06/02/2022 and therefore, a violation of this applicable rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the current status of the license remain unchanged.

08/09/2022

Elizabeth Elliott Date
Licensing Consultant

Approved By:

08/09/2022

Jerry Hendrick Date
Area Manager