GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 6, 2022

Teresa Fowler
Vineyard Assisted Living, LLC
14420 S. Helmer Rd.
Battle Creek, MI 49015

RE: License #: AH390391941
Investigation #: 2022A1028048
Vineyard Assisted Living

Dear Ms. Fowler:

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 #:	AH390391941
Investigation #:	2022A1028048
Complaint Receipt Date:	06/06/2022
Investigation Initiation Date:	06/06/2022
Report Due Date:	08/06/2022
Licensee Name:	Vineyard Assisted Living, LLC
Licensee Address:	8170 Vineyard Parkway Kalamazoo, MI 49009
Licensee Telephone #:	(269) 775-0001
Authorized Representative/Administrator:	Teresa Fowler
Name of Facility:	Vineyard Assisted Living
Facility Address:	8170 Vineyard Parkway Kalamazoo, MI 49009
Facility Telephone #:	(269) 775-0001
Original Issuance Date:	10/31/2018
License **Status:**	REGULAR
Effective Date:	04/30/2022
Expiration Date:	04/29/2023
Capacity:	85
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident A eloped from the facility.	Yes
The facility did not provide an appropriate discharge for Resident A.	Yes

III. METHODOLOGY

05/31/2022	Contact – Document Received Received incident report for Resident A from facility.
05/31/2022	Contact – Document Requested Discharge document and information requested by department from the facility.
05/31/2022	Contact – Email Received Information received to department from facility authorized representative/administrator, Teresa Fowler.
05/31/2022	Contact – Document Received Received Resident A's service plan from Employee A.
06/062022	Special Investigation Intake 2022A1028048
06/06/2022	Special Investigation Initiated - Letter 2022A1028048
06/06/2022	APS Referral 2022A1028048
10/06/2022	Exit Interview

ALLEGATION:

Resident A eloped from the facility.

INVESTIGATION:

On 5/31/2022, the department received an incident report for Resident A via email from the facility. Per the incident report, Resident A was outside on the patio of

[their] room at 12:45pm on 5/30/2022 when lunch was served. At 1:00pm, Resident A was then seen by a facility staff member walking in the parking but the facility staff member "did not think anything of this, [the facility staff member] thought [Resident A] was walking to a car". At 1:55pm, Resident A was brought back to the facility by a concerned citizen. The unidentified concerned citizen left the facility, and Resident A began to walk down the street again away from the facility, requiring redirection from facility staff. When questioned by facility staff about the incident, Resident A reported to facility staff that [they] wanted "get out and about, see the nice day". Resident A reported [they] left the facility around 1:30pm before being picked up by the concerned citizen. Resident A was assessed upon return to the facility with no injuries noted and Resident A's authorized representative and physician were notified of the incident as well. The incident report also read:

[Resident A] has had no prior attempts of leaving the facility unaccompanied. [Resident A's authorized representative] notified to pick up [Resident A] since community could not provide 1:1 care. Left with [authorized representative] at 3:30pm….[Resident A's authorized representative] was given the option of coming in to be with [Resident A], hire an outside agency to provide 1:1 sitting service or take [Resident A] home with [them] until a resolution could be reached regarding [sic] ability to remain at Vineyard. [Resident A] left with [authorized representative] at 3:30pm. At the time of this submission, [Resident A] remains with [their authorized representative].

On 5/31/2022, due to the nature of the report and the actions of the facility reported within the incident report, I requested Resident A's service plan and discharge from the facility.

On 5/31/2022, at 3:45pm, I received the following email correspondence from the facility authorized representative/administrator Teresa Fowler:

Julie,

[Employee A] is forwarding you the service plan. I did not issue a discharge to the [authorized representative], as [they were] given the opportunity to provide one on one supervision at the building and chose to take [Resident A] home. I met with [the authorized representative] a short while ago and [they are] looking for a secure memory care for [Resident A] and we have provided [them] with a list of available options in the area. Due to the fact that this is a mutual agreement, I did not issue a discharge. Please advise if I need to do so in this case.

Thank you.

On 5/31/2022 at 3:56pm, I responded to Ms. Fowler's email with the following:

Hi Terri,

A discharge should have been issued since the resident left the building.

Kind Regards,

Julie Viviano

On 5/31/2022 at 3:56pm, Ms. Fowler immediately responded via email:

I can do one now and send it to [the authorized representative]. Would you like a copy?

On 5/31/2022 at 4:28pm, I received a copy of Resident A's discharge from Ms. Fowler.

On 5/31/2022 at 9:38pm, I received a copy of Resident A's service plan from Employee A.

On 6/1/2022, I reviewed Resident A's service plan which was last updated and signed on 5/12/22. The service plan revealed Resident A is independent with feeding, grooming, dressing, toileting, transfers, and with use of walker. The facility manages Resident A's medications, laundry, meals, and housekeeping. Resident A requires assistance with transportation. Resident A requires reminders for orientation.

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: **(a) Assume full legal responsibility for the overall conduct and operation of the home.** **(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.** **(c) Assure the availability of emergency medical care required by a resident.** **(d) Appoint a competent administrator who is responsible for operating the home in accordance with the established policies of the home.**

ANALYSIS:	Resident A eloped from the facility on 5/31/22. Review of incident documentation revealed Resident A was last seen by a facility staff member in the facility parking lot at 1:00pm. The facility was unaware Resident A had left the facility premises on 5/31/22 until a concerned citizen returned Resident A to the facility at 1:55pm. Review of Resident A's service plan reveals Resident A requires reminders for orientation. While Resident A did not incur any injury during the elopement, the facility did not provide Resident A appropriate supervision to ensure Resident A's safety and protection or to prevent Resident A's elopement.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The facility did not provide an appropriate discharge for Resident A.

INVESTIGATION:

On 5/31/2022, I was notified of Resident A's elopement from the facility by an incident report via email from the facility. Per the incident report, Resident A's authorized representative was provided the following options by the facility to address Resident A's incident:

- *Pick up [Resident A] since community could not provide 1:1 care.*
- *Given the option of coming in to be with [Resident A].*
- *Hire an outside agency to provide 1:1 sitting service.*
- *Take [Resident A] home with [them] until a resolution could be reached regarding [sic] ability to remain at Vineyard.*

The incident report also read*: [Resident A] left with [authorized representative] at 3:30pm. At the time of this submission, [Resident A] remains with [their authorized representative];* and that *[Resident A] has had no prior attempts of leaving the facility unaccompanied.*

On 5/31/2022, I emailed Ms. Fowler questioning if Resident A was to be discharged from the facility and had a discharged been issued. Ms. Fowler responded via email a discharge was not issued to Resident A or their authorized representative "*as [they were] given the opportunity to provide one on one supervision at the building and chose to take [Resident A] home…. Due to the fact that this is a mutual agreement, I did not issue a discharge."*

On 5/31/2022, I informed Ms. Fowler a discharge should have been issued for Resident A due to Resident A exiting the facility. Ms. Fowler reported Resident A's authorized representative is looking for another placement for Resident A. Ms. Fowler subsequently wrote a discharge letter and emailed it to me after Resident A had already exited the facility.

On 6/1/2022, I reviewed the discharge for Resident A which revealed the following:

- Rules R325.1922, Rule 22. numbers 8 and 15 were given as reason for discharge.
  (8) A home shall not retain a resident if the resident has harmed himself or herself or others, or has demonstrated behaviors that pose a risk of serious harm to himself or herself or others, unless the home has the capacity to manage the resident's behavior.
  (15) A home may discharge a resident before the 30-day notice if the home has determined and documented that either, or both, of the following exist: (a) Substantial risk to the resident due to the inability of the home to meet the resident's needs or due to the inability of the home to assure the safety and well-being of the resident, other residents, visitors, or staff of the home.

- The following incident description was provided in the discharge: *On May 30, 2022 resident George Quinn left Vineyard Assisted Living unaccompanied, and was brought back to the building by a concerned citizen. Once returned to the building, Mr. Quinn attempted to leave the premises again and was directed back to the building. Mr. Quinn has no recollection of these events. Vineyard Assisted Living does not offer the type of supervision which Mr. Quinn requires to ensure he is not placing himself at risk.*

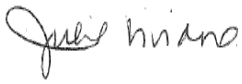
As of 6/23/2022, I have been unable to make contact with Resident A's authorized representative for this investigation.

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(15) A home may discharge a resident before the 30-day notice if the home has determined and documented that either, or both, of the following exist: **(a) Substantial risk to the resident due to the inability of the home to meet the resident's needs or due to the inability of the home to assure the safety and well-being of the resident, other residents, visitors, or staff of the home.**

ANALYSIS:	Resident A and their authorized representative were not provided an appropriate discharge after Resident A eloped from the facility on 5/30/22. The discharge was provided only after the department inquired about it and after Resident A had already exited the facility A discharge must be issued verbally and in writing to both the resident and their authorized representative prior to being discharged from the facility. The facility included Rule 325.1922 (8) in Resident A's discharge. • This rule reads: *A home shall not retain a resident if the resident has harmed himself or herself or others, or has demonstrated behaviors that pose a risk of serious harm to himself or herself or others, unless the home has the capacity to manage the resident's behavior.* However, the facility did not demonstrate that Resident A is a harm to [their] self or others or that Resident A has demonstrated a consistent pattern of behaviors that pose a risk of serious harm. Facility documentation revealed this was Resident A's first elopement attempt and that Resident A had no prior attempts. Rule 325.1922 (15) was included in Resident A's discharge. • This rule reads: *A home may discharge a resident before the 30-day notice if the home has determined and documented that either, or both, of the following exist: (a) Substantial risk to the resident due to the inability of the home to meet the resident's needs or due to the inability of the home to assure the safety and well-being of the resident, other residents, visitors, or staff of the home.* However, the facility did not demonstrate that Resident A was a substantial risk or that the home was unable to meet the needs of Resident A, as no attempted alternatives made by the facility were included in the discharge notice. No alternative measures by the facility were included in Resident A's service plan either which was last updated 5/12/22. Therefore, the facility did not issue an appropriate discharge concerning Resident A and did not follow discharge protocol for Resident A and is in violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon an acceptable corrective action plan, I recommend this license remain unchanged.



6/22/2022

Julie Viviano Date
Licensing Staff

Approved By:

10/05/2022

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