GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 20, 2022

Jeni Lockhart
Alternative Community Living, Inc.
P. O. Box 190179
Burton, MI 48519

RE: License #: AM190095524
Investigation #: 2022A0466053
Eureka House

Dear Ms. Lockhart:

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 (517) 284-9727.

Sincerely,

Julie Elkins, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

## I. IDENTIFYING INFORMATION

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|---|---|
| **License #:** | AM190095524 |
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| **Investigation #:** | 2022A0466053 |
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| **Complaint Receipt Date:** | 07/29/2022 |
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| **Investigation Initiation Date:** | 08/01/2022 |
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| **Report Due Date:** | 09/27/2022 |
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| **Licensee Name:** | Alternative Community Living, Inc. |
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| **Licensee Address:** | P. O. Box 190179<br>Burton, MI 48519 |
| | |
| **Licensee Telephone #:** | (248) 505-1987 |
| | |
| **Administrator:** | Jeni Lockhart |
| | |
| **Licensee Designee:** | Jeni Lockhart |
| | |
| **Name of Facility:** | Eureka House |
| | |
| **Facility Address:** | 7808 Freemont<br>Eureka, MI 48833 |
| | |
| **Facility Telephone #:** | (989) 224-0290 |
| | |
| **Original Issuance Date:** | 06/04/2001 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 03/19/2022 |
| | |
| **Expiration Date:** | 03/18/2024 |
| | |
| **Capacity:** | 12 |
| | |
| **Program Type:** | MENTALLY ILL |

## II. ALLEGATION:

| | **Violation Established**? |
|---|---|
| Resident A is not being provided with the supervision that she requires. | Yes |
| Additional Findings | Yes |

## III. METHODOLOGY

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|---|---|
| 07/29/2022 | Special Investigation Intake- 2022A0466053. |
| 08/01/2022 | Special Investigation Initiated – Letter/Email from assigned licensing consultant Leslie Herrguth. |
| 08/03/2022 | Inspection Completed On-site with licensing consultant Kevin Sellers. |
| 08/03/2022 | Contact Documents Received from licensee designee Jeni Lockhart. |
| 08/30/2022 | Contact Documents sent to licensee designee Jeni Lockhart. |
| 08/30/2022 | Contact Documents Received from licensee designee Jeni Lockhart. |
| 09/01/2022 | Contact- Document sent/received to/from Leslie Herrguth. |
| 09/06/2022 | Contact- Telephone call made to DCW Rickel Grinnel, interviewed. |
| 09/06/2022 | Contact- Telephone call made to DCW Danyle Jones, message left. |
| 09/16/2022 | Exit Conference with licensee designee Jeni Lockhart. |

**ALLEGATION: Resident A is not being provided with the supervision that she requires.**

**INVESTIGATION:**
On 07/29/2022, Complainant reported Resident A eloped from the facility. Complainant reported Resident A has left the facility without supervision before but staff members have been able to follow her. Complainant reported that this time Resident A eloped without the staff being aware that she had left the facility. Complainant reported it is believed about 15 minutes after Resident A left, direct

care staff noticed she was gone and called police. Complainant reported concern is facility direct care staff does not have any additional corrective measures in place to try to deter Resident A's elopement behaviors as the facility plans to continue conducting 15 minutes checks and notifying the psychiatrist. Complainant reported facility direct care staff members were monitoring Resident A with 15-minute checks when they realized that Resident A had eloped on 07/29/2022.

On 07/29/2022, I reviewed an *Adult Foster Care (AFC) licensing division Incident/Accident Report* dated 07/27/2022 at 10:05pm and written by direct care worker (DCW) Mackenzie Schueller. In the "Explain What Happened" section of the report it stated, "Staff went upstairs to check on [Resident A] and she wasn't in her bedroom or bathroom. Staff looked all over the house and outside on the property and she wasn't found." In the "Action taken by Staff" section of the report it stated, "Staff called 911 and they sent a sheriff out to look for her and manager Dannyle was on her way into work and looked for her on her way and continued to look for her once she arrived at the house." In the "Corrective Measures Taken to Remedy and/or Prevent Recurrence" section of the report it stated, "Sheriff's department involvement. Following Crisis Plan. Contacted Guardian, Case Manager and Supervisor. Staff drove around to find her. She returned at 11:30 p.m. She was dropped off by a stranger. Follow up with Psychiatrist."

On 08/03/2022, licensing consultant Kevin Sellers and I conducted an unannounced investigation and we interviewed DCW Glenda Black and DCW Mary Molonia. DCW Black and DCW Molonia both reported Resident A does leave the facility often and wanders the community. DCW Black and DCW Molonia reported neither of them were working on 07/27/2022 when Resident A left the facility without telling anyone. DCW Black and DCW Molonia both reported Resident A was not at the facility currently rather Resident A was hospitalized on 07/28/2022 for medication non-compliance due to a petition filed by community mental health (CMH). DCW Black and DCW Molonia reported Resident A is often delusional and always believes someone is coming to pick her up and when they do not arrive, she leaves the facility to look for them. DCW Black and DCW Molonia both reported Resident A is independent and is permitted to be in the community without supervision. DCW Black and DCW Molonia reported Resident A has had delusional behaviors for the past several months and that she has eloped dozens of times each month in April, May, June and July 2022. DCW Black and DCW Molonia reported that over the past several months Resident A has left the facility dozens of times without letting a DCW know that she was leaving. DCW Black and DCW Molonia both reported that if Resident A lets someone know that she is leaving a DCW will go with her. DCW Black and DCW Molonia both reported DCWs do 15-minute checks on Resident A. DCW Black and DCW Molonia both reported not much more can be done when Resident A leaves the facility without telling anyone. It should be noted that at the date/time that these interviews took place, I did not have access to Resident A's written *(AFC) assessment plan* as DCW Black and DCW Molonia could not access the electronic record for me to review at the time of the investigation.

On 08/03/2022 I reviewed Resident A's record which was provided by licensee designee Jeni Lockhart which contained a written *Assessment Plan for AFC Residents* documented, in the "Moves independently in the community" section of the report it stated, "no, she walks in the middle of the road and wanders." This document was signed by Resident A's case manager, Sarah Howard.

On 08/03/2022, I reviewed Resident A's *Crisis Plan* written by Community Mental Health (CMH) of Clinton, Eaton and Ingham (CEI). In the "crisis related and information" section of the report it stated, "Client wanders off from AFC unaware of where she is or what she is doing. She has repeatedly asked strangers for rides, been picked up by the police and been found walking down the highway." In the "Suggested strategies" section of the report it stated, "Home staff will do safety checks on client every 15 minutes. Home staff will encourage client to participate in household activities or events. Home staff will remind client that is she walks off they will have to call 911."

On 09/06/2022, I interviewed DCW Rickel Grinnelle who reported that she was not on duty when Resident A eloped but that she worked the following morning. DCW Grinnelle reported Resident A wanders away from the facility often and she walks in the street which is concerning. Initially, DCW Grinnelle reported that "legally [Resident A] is allowed to be in the community unsupervised as they are not allowed to have rules preventing that." DCW Grinnelle acknowledged Resident A's *written AFC assessment plan* requires Resident A to have supervision in the community but reported that "[Resident A] leaves without letting any of the DCWs know so there's not much they can do." DCW Grinnelle reported Resident A has had delusional behaviors for the past several months and that she has eloped dozens of times each month in April, May, June and July 2022. Initially, DCW Grinnelle reported DCWs check on Resident A were conducted every 20-30 minutes, then DCW Grinnelle reported that DCWs check on Resident A are done every 15- 20 minutes. DCW Grinnelle reported DCWs offer to take a walk with Resident A but Resident A prefers to walk alone so she will leave the facility without telling anyone.

| **APPLICABLE RULE** | |
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| **R 400.14301** | **Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.** |
| | **(2) A licensee shall not accept or retain a resident for care unless and until the licensee has completed a written assessment of the resident and determined that the resident is suitable pursuant to all of the following provisions:**<br>**(a) The amount of personal care, supervision, and protection that is required by the resident is available in the home**. |

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| **ANALYSIS:** | Resident A's record contained a written *AFC assessment plan* that documented, in the "Moves independently in the community" section of the report stated, "no, she walks in the middle of the road and wanders."<br><br>DCW Black, DCW Molonia and DCW Grinnelle reported Resident A has had delusional behaviors for the past several months and that she has eloped dozens of times during the months of April, May, June and July 2022 to wander the community. DCW Black, DCW Molonia and DCW Grinnelle reported a direct care worker goes with Resident A if she reports wanting to leave the facility. Based on Resident A's elopement on 07/27/2022 along with multiple other elopements during April, May, June, and July 2022, the amount of personal care, supervision, and protection Resident A needs is not being provided by the licensee. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**ADDITIONAL FINDINGS:**

**INVESTIGATION:**
On 08/03/2022 licensee designee Lockhart provided me a copy of Resident A's written *Assessment Plan for AFC Residents* that documented in the "date assessment was completed" section of the report "05/12/2022." The only signature on the document was Sarah Howard and it was dated 5/13/2020. I did not find any other documentation in the file such as a letter or email verifying Guardian A1 nor licensee designee Lockhart participated in any way in the completion of the document. The written assessment plan was not signed by Guardian A1 nor licensee designee Lockhart therefore there is no documentation either Guardian A1 or licensee designee Lockhart participated in the completion of the plan.

| **APPLICABLE RULE** | |
|---|---|
| **R 400.14301** | **Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.** |
| | **(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.** |

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| **ANALYSIS:** | The most recent version of Resident A's written *Assessment Plan for AFC Residents* did not verify that either Guardian A1 or licensee designee participated in the completion of the required annual document. The most recently dated assessment plan that was completed by all required parties was 05/13/2020. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**INVESTIGATION:**

On 07/29/2022, DCW Black, DCW Molonia and license designee Lockhart all reported Resident A was not at the facility as Resident A was hospitalized on 07/28/2022.

On 08/31/2022, licensee designee Lockhart reported Resident A has not returned to the facility. Licensee designee Lockhart reported Resident A remains at Sparrow Hospital.

On 09/01/2022, I interviewed licensing consultant Leslie Herrguth who reported she reviewed the facility file and the department never received an *Adult Foster Care (AFC) licensing division Incident/Accident Report* documenting Resident A had been hospitalized.

On 09/06/2022, I interviewed DCW Grinnelle who reported Resident A has not returned to the facility as she remains hospitalized. DCW Grinnelle reported Resident A was hospitalized on 07/28/2022.

| **APPLICABLE RULE** | |
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| **R 400.14311** | **Investigation and reporting of incidents, accidents, illnesses, absences, and death.** |
| | **(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following:**<br>**(b) Any accident or illness that requires hospitalization.** |
| **ANALYSIS:** | The adult foster care licensing division was not provided with written notification that Resident A was hospitalized on 07/28/2022. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**INVESTIGATION:**
On 08/03/2022, licensing consultant Sellers and I conducted an unannounced investigation and we interviewed DCW Black and DCW Molonia who both reported neither of them was proficient with the facility's electronic files so neither could provide Resident A's resident record for review. DCW Black contacted licensee designee Lockhart by phone to obtain assistance and/or direction to obtain resident records.

On 08/03/2022, I interviewed licensee designee Lockhart who reported she was aware resident records are required to be accessible to the department at the time of investigation/inspection. Licensee Lockhart reported she had not had time to train all DCWs on the electronic file system which contained resident records. Licensee Lockhart acknowledged licensing consultant Leslie Herrguth told her that the resident records are required to be available for review at the time of any investigation/inspection. Licensee Lockhart reported that she would email me the documents that I requested.

| **APPLICABLE RULE** | |
|---|---|
| **R 400.14316** | **Resident records.** |
| | **(1) A licensee shall complete, and maintain in the home, a separate record for each resident and shall provide record information as required by the department. A resident record shall include, at a minimum, all of the following information:**<br>**(a) Identifying information, including, at a minimum, all of the following:**<br>**(i) Name.**<br>**(ii) Social security number, date of birth, case number, and marital status.**<br>**(iii) Former address.**<br>**(iv) Name, address, and telephone number of the next of kin or the designated representative.**<br>**(v) Name, address, and telephone number of the person and agency responsible for the resident's placement in the home.**<br>**(vi) Name, address, and telephone number of the preferred physician and hospital.**<br>**(vii) Medical insurance.**<br>**(viii) Funeral provisions and preferences.**<br>**(ix) Resident's religious preference information.**<br>**(b) Date of admission.**<br>**(c) Date of discharge and the place to which the resident was discharged.**<br>**(d) Health care information, including all of the following:** |

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| | **(i) Health care appraisals.**<br>**(ii) Medication logs.**<br>**(iii) Statements and instructions for supervising prescribed medication, including dietary supplements and individual special medical procedures.**<br>**(iv) A record of physician contacts.**<br>**(v) Instructions for emergency care and advanced medical directives.**<br>**(e) Resident care agreement.**<br>**(f) Assessment plan.**<br>**(g) Weight record.**<br>**(h) Incident reports and accident records.**<br>**(i) Resident funds and valuables record and resident refund agreement.**<br>**(j) Resident grievances and complaints.** |
| **ANALYSIS:** | On 08/03/2022, licensing consultant Sellers and I conducted an unannounced investigation and DCW Black and DCW Molonia could not provide Resident A's record for department review as they were not trained on how to access/use the electronic resident records system. Therefore, a violation has been established. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

## IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, no change in license is recommended.

09/16/2022

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Julie Elkins Date
Licensing Consultant

Approved By:

09/20/2022

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Dawn N. Timm Date
Area Manager