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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 21, 2022

Tracey Holt
Hearthside Assisted Living
1501 W. 6th Ave.
Sault Ste. Marie, MI 49783

RE: License #:	AH170271455
Investigation #:	2023A1021016
	Hearthside Assisted Living

Dear Ms. Holt:

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 authorized representative 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) 284-9730.

Sincerely,

Kimberly Horst, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH170271455
Investigation #:	2023A1021016
Complaint Receipt Date:	10/30/2022
Investigation Initiation Date:	10/31/2022
Report Due Date:	12/29/2022
Licensee Name:	Superior Health Support Systems
Licensee Address:	Suite 120 1501 W. 6th Ave. Sault Ste. Marie, MI 49783
Licensee Telephone #:	(906) 632-9886
Administrator/ Authorized Representative:	Tracey Holt
Name of Facility:	Hearthside Assisted Living
Facility Address:	1501 W. 6th Ave. Sault Ste. Marie, MI 49783
Facility Telephone #:	(906) 635-6911
Original Issuance Date:	08/01/2006
License Status:	REGULAR
Effective Date:	11/03/2022
Expiration Date:	11/02/2023
Capacity:	64
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident C eloped from the facility.	Yes
Additional Findings	Yes

III. METHODOLOGY

10/30/2022	Special Investigation Intake 2023A1021016
10/31/2022	Special Investigation Initiated - Telephone interviewed administrator
11/10/2022	Inspection Completed On-site
11/10/2022	Contact - Document Received received documents
11/15/2022	Contact-Telephone call made Interviewed SP3
11/21/2022	Exit Conference Exit conference with authorized representative Tracey Holt

ALLEGATION:

Resident C eloped from the facility.

INVESTIGATION:

On 10/31/22, the licensing department received an incident report that read,

"At 1902 I received a call from staff person 3 (SP3) at Hearthside Assisted Living. She stated (Resident C) is missing from the building and she has had staff search the building and surrounding area. I let her know she needs to call the police immediately and call family.

I then contacted David Pietrangelo, SHSS VP Board. He said he was on his way to the Hearthside. I then contacted The Merlin Home, next door to Hearthside, and have one of their staff members look outside of the home to ensure resident wasn't there.

I arrived at Hearthside @1903. Dave was starting to view video footage to find out when resident was last in the building. At this time staff noted that she did eat her dinner in the dining room at 1700.

Upon review of camera resident was noted leaving the West suite emergency exit at 1722. Staff member was noted cancelling the alarm but not checking the door.

Police had just started a door to door search when the call came that Dave found resident, lying in the ditch. Police and I immediately went to the scene. Resident was lying on her side and her feet were stuck under the fence. We removed resident from the ditch and carried her to the side of the road. General assessment showed resident to be cold but no other injuries noted. She had no complaints of pain and she was verbal. I sat on the road and had resident lean into me for warmth and reassurance. The police had already called for an ambulance. When ambulance arrived resident was taken to MiMichigan health to ensure she didn't have hypothermia.

I left the ER and returned to Hearthside where I met with (SP3). She was very upset and apologized. I asked about contacting the family and she said that when the police took over, she thought they were calling family as all information was given to them.

Later in the evening after resident was found I asked staff why she turned the alarm off without checking the door. She stated another resident was walking down the hall and assumed it was him who opened the door. I educated the employee on the importance of always checking the door before turning off the alarm. She assured me this would never happen again."

On 10/31/22, I interviewed director Delores Kivi by telephone. Ms. Kivi reported Resident C has a history of elopement and tried to leave the facility last year. Ms. Kivi reported on 10/29/22, Resident C ate dinner and then exited the building. Ms. Kivi reported the door alarm went off and SP4 turned off the alarm as she thought a resident pushed the door but did not exit. Ms. Kivi reported when another caregiver went to toilet Resident C it was found that Resident C was not in the building. Ms. Kivi reported caregivers searched inside the building and outside. Ms. Kivi reported the shift supervisor contacted her and then the police was contacted. Ms. Kivi reported herself, Dave, and the police started to do walking searches. Ms. Kivi reported Dave found Resident C in a ditch. Ms. Kivi reported Resident C was transported to the emergency room for an assessment. Ms. Kivi reported Resident C did not have any injuries and did not receive any new orders. Ms. Kivi reported the shift supervisor did not contact family as she believed the police were to contact family. Ms. Kivi reported SP4 was hired in April and completed elopement training. Ms. Kivi reported she provided additional training to SP4. Ms. Kivi reported video footage revealed Resident C finished dinner around 5:20pm, caregivers realized

Resident C was missing at 6:40pm, police was called at 6:58pm, and Resident C was found at 7:53pm.

On 11/15/22, I interviewed SP3 by telephone. SP3 reported she worked when Resident C eloped from the facility. SP3 reported she was notified by care aids at 7:00pm that they went to toilet Resident C, and she could not be located. SP3 reported care aids checked inside and outside the facility. SP3 reported she contacted Ms. Kivi and then the police were contacted. SP3 reported when the police arrived at the facility there was miscommunication, and she believed the police contacted family. SP3 reported Resident C was found in a ditch and was transported to the hospital. SP3 reported Resident C did try to elope within the past year. SP3 reported Resident C does wander throughout the facility. SP3 reported care aids typically follow Resident C throughout the facility to ensure safety but a new PRN medication has been ordered for Resident C.

I reviewed progress notes for Resident C. The notes read,

> *"9/24/22: Resident had a lot of wandering around in the afternoon.*
> *10/3/22: Resident had a good day. No problems. Not a lot of going out the door today.*
> *10/13/22: Res had a good day. Only went down West Hall once but was quickly redirected.*
> *10/19/22: Resident was up and wandering and going down West Hall.*
> *10/29/22: Eloped out the suite door and found up the road around the corner. No injures."*

I reviewed Resident C's service plan. The service plan read,

> *"Cue hand rails, when door alarm goes off ensure Res is in home. Staff to toilet every 2 hours and as needed. Elopement Risk. Wanders yes."*

I reviewed the facility Resident Elopement Policy. The policy read,

> *"1. The shift supervisor will immediately check the resident sign out forms in the medication office.*
> *2. Staff #1 (shift supervisor) will search inside of the home. Staff #2 (resident aid) will quickly search the immediate area surrounding the building. If there is a Staff #3 this staff will assist Staff #1 in searching outside.*
> *3. if the resident has not been found in the home or on the grounds, call 911. Give the following information:*
> *Your name and address. The name of the resident and the time noted missing. A description of the resident whether resident will respond to name, suggestions that may help in handling the Resident and suggestions that may help in locating the Resident.*
> *4. If there is a third staff person, this individual will then get into a vehicle, if available, and begin to search the neighboring areas.*

5. When the police arrive give them a copy of the Residents picture from the MAR.
6. Once 9-1-1 has been notified, contact the CEO at 322-4313 or the manager at 440-7306 so that he/she might assist in the search. If necessary, call any other available personnel using the personnel contact list.
7. Notify any family members or responsible parities. Also notify any neighbors who may know the Resident and can assist in the search.
8. When the Resident is returned, do a thorough body check to see if any injury has occurred. Try to determine if any substance has been ingested. Contact the Emergency Department, if necessary.
9. The Shift Supervisor shall contact everyone previously contacted that the Resident has been returned to SHSS.
10. The Shift Supervisor shall contact the CEO and report the Residents condition.
11. The Shift Supervisor shall document in the Resident's progress notes regarding the elopement.
12. The Shift Supervisor shall document on an unusual occurrence from, the 72 hour incident/accident observation report and in the communication book.
13. The Shift Supervisor shall apply a wander guard to the Resident."

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: **(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.**
For Reference: R 325.1901	**Definitions.**
	(22) "Supervision" means guidance of a resident in the activities of daily living, and includes all of the following: **(d) Being aware of a resident's general whereabouts as indicated in the resident's service plan, even though the resident may travel independently about the community.**
ANALYSIS:	Resident C was known to be confused and wander throughout the facility. Resident C exhibited these behaviors between 9/24-10/29. Resident C's service plan was not updated during this period to reflect her increasing need for supervision. Specifically, it lacked the level of one-to-one supervision she required due to her consistently demonstrated behaviors and cognitive deficits. Due to this insufficiently developed plan, staff were not aware of her whereabouts allowing her to elope

	unnoticed and at risk of harm by leaving the facility unsupervised. The facility lacked an organized program of supervision and reasonable protective measures to keep her safe.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Ms. Kivi reported the facility did have a wander guard system, but it broke in January 2022. Ms. Kivi reported the facility contacted customer service multiple times, but the system was unable to be fixed. Ms. Kivi reported since this incident occurred, the facility will now get a new system.

APPLICABLE RULE	
R 325.1979	**General maintenance and storage.**
	(1) The building, equipment, and furniture shall be kept clean and in good repair.
ANALYSIS:	Interviews conducted revealed the facility has been without a wander guard system for 10 months.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

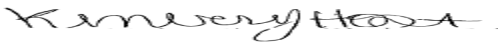
SP4 was trained in the elopement policy. However, her training documents were not located in her employee record.

APPLICABLE RULE	
R 325.1944 (1)	**Employee records and work schedules.**
	(1) A home shall maintain a record for each employee which shall include all of the following: **(d) Summary of experience, education, and training.**
ANALYSIS:	The facility could not produce record of SP4's training.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 11/21/22, I conducted an exit conference with authorized representative Tracey Holt by telephone.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the status of the license.



11/16/22

Kimberly Horst — Date
Licensing Staff

Approved By:

11/16/2022

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