GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 26, 2023

Mark McNeary
Midland Retirement, LLC
PO Box 1359
Aberdeen, SD 57402

RE: License #: AH560387542
Investigation #: 2023A0585031
Primrose of Midland

Dear Mr. McNeary:

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) 284-9730.

Sincerely,

Brender Howard, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street, P.O. Box 30664
Lansing, MI 48909
(313) 268-1788
enclosure

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

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AH560387542 |
| | |
| **Investigation #:** | 2023A0585031 |
| | |
| **Complaint Receipt Date:** | 02/09/2023 |
| | |
| **Investigation Initiation Date:** | 02/10/2023 |
| | |
| **Report Due Date:** | 04/11/2023 |
| | |
| **Licensee Name:** | Midland Retirement, LLC |
| | |
| **Licensee Address:** | 815 N 2nd Street<br>Aberdeen, SD 57401 |
| | |
| **Licensee Telephone #:** | Unknown |
| | |
| **Administrator:** | Myndy Sanders |
| | |
| **Authorized Representative:** | Mark McNeary |
| | |
| **Name of Facility:** | Primrose of Midland |
| | |
| **Facility Address:** | 5600 N. Waldo Road<br>Midland, MI 48640 |
| | |
| **Facility Telephone #:** | (989) 575-3255 |
| | |
| **Original Issuance Date:** | 05/31/2019 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 11/30/2022 |
| | |
| **Expiration Date:** | 11/29/2023 |
| | |
| **Capacity:** | 106 |
| | |
| **Program Type:** | AGED<br>ALZHEIMERS |

## II. ALLEGATION(S)

| | Violation Established? |
|---|---|
| Resident A eloped twice from the facility. | Yes |
| The incident was not reported to the State. | No |
| Additional Findings | No |

## III. METHODOLOGY

| | |
|---|---|
| 02/09/2023 | Special Investigation Intake<br>2023A0585031 |
| 02/10/2023 | Special Investigation Initiated - Letter<br>Emailed the allegations to Adult Protective Services (APS). |
| 02/10/2023 | Contact - Telephone call made.<br>Called the complainant to discuss allegations. |
| 02/14/2023 | Inspection Completed On-site<br>Completed with observation, interview and record review. |
| | |
| | |

**ALLEGATION:**

**Resident A eloped twice from the facility.**

**INVESTIGATION:**

On 2/8/2023 the department received the complaint from Adult Protective Services (APS) via the BCHS Online Complaint website. The complaint alleged that Resident A eloped from the facility twice on 9/3/2022. The complaint alleged that she fell into a ditch and broke her shoulder.

On 2/14/2023, I interviewed APS worker Kathy Anders by telephone. She stated that the incident was reported to her that Resident A had frequent incidents of leaving the facility. She stated that Resident A left the facility at 4:00 a.m. and a couple hour later she left again. She stated that Resident A was found four hours later by a search group who rescued her. Ms. Anders stated that Resident A was in terrible shape and was in the hospital for three weeks.

On 2/14/2023, an onsite was completed at the facility.  During the onsite, I interviewed administrator Myndy Sanders. She stated that Resident A went out the back entry.  She stated that they are working with the family.  Ms. Sanders stated that Resident A was a wanderer.  She stated that Resident A pushed through the egress door.  She stated that it has been other times when Resident A have attempted to get out, but staff got her.  She stated when the door opens; the alarm goes off.  Ms. Sanders stated that the aide on duty that night had her phone volume turned down.  She stated that assistant living staff came over immediately to assist in the search for Resident A.  She said the alarm had been going off for fifteen minutes.  She stated that they search for three to four hours.  She stated that the police and fire department came to the facility.  Ms. Sanders said that Resident A was found at 10:21 a.m. after walking out at 5:35 a.m.  Ms. Sanders explained that the census was 17 in memory care and there was one aide with a floater which goes from memory care to assisted living.  She stated that the staff was terminated because there were signs and staff did not pay attention.  She said that it is against the facility policy to turn the volume down on phones.  She stated that they have since put up a sticker on the door that looks like a library that would deter the residents from going out the door.  She stated that police told them not to search the road because they had a dog, and a search team came.  She stated, Resident A was found with injuries and was sent to the hospital.

On 2/14/2023, I interviewed Employee #1 at the facility.  Employee #1 stated that there is a receptionist on duty five days a week and the door is locked at night with an alarm on it.

Resident A's evaluation (Service plan) with the finalized date of 8/22/22 read, "Resident had increased exit seeking behavior with exiting.  Staff is to offer resident walks outside in attempt to curb exit seeking when she comes in.  Please report if walks are helpful….Elopement assessment  will be completed at least annually (or sooner if indicated) Staff will observe for and report any changes noted in wandering pattern."

Incident report with the timeline read:

5:35 a.m. memory care aide enters apartment.
5:35:46 a.m. – Resident exits building and alarm "tamper lid raised", MC exit to outside goes off (alarm is resolved by MC aide #1 15m 57s later as seen on Ciscor report).
5:47:17 am – MC aide #1 exits apartment.
5:48:08am – Aide #2 enters MC unit and walks to resident room and loops around the entire unit.
5:49:55 a.m. – Aide #2 contact care staff that she has searched MC.

5:50:17 a.m. – Aide #2 approaches aide #1 and both begin to go door to door in MC.
5:57 a.m. – Aide #3 enters MC and start looking room to room.
5:59 a.m. – Aide #2 exits MC vestibule door and crosses the parking lot to look in club house and MC drive.
6:02 a.m. – Aide #3 exits building through MC exit door and begins looking from Villa to Villa.
6:03 a.m. – Aide #3 calls on-call nurse.
6:04 a.m. – Aide #3 calls Myndy Sanders who prepares to go to the building.
6:27 a.m. – 911 called.
6:50 a.m. – Myndy Sanders arrives to building and begins reviewing cameras. Resident can be seen exiting the MC exit door at 5:35 a.m. and is on camera walking south then west around campus. She follows the drive to where it merges with Waldo Road and heads north. Resident can no longer be clearly seen on camera after 5:43:06 a.m.
6:52 a.m. – First police officer arrives at the building. Police communicate that they are bringing a tracking dog and implementing a drone to help in the search. At this time, 5-7 officers are in the area searching.
9:40 a.m. – Police post on their public Facebook page about search for resident. DON stays at building as point person and administrator, LE, and maintenance start search by personal vehicles. DON did elopement training with staff.
10:21 a.m. – Myndy Sanders was informed 911 was contacted for rescue evaluation of found resident.

CTscans completed on resident showed right shoulder/arm fracture and nasal fracture. Lacerations on left forearm, forehead, and nose. Resident was admitted for at minimum 2 night stay for evaluation. At this time no surgery will be needed for arm shoulder fractures. Resident will need to wear a sling for the duration of healing.

Community will evaluate resident for appropriateness of return to the community. Administrator spoke to resident's daughter who was out of town and facility will provide one on one care as a short-term solution to resident behaviors and work with resident family as well as PCP to determine future appropriate interventions.

| 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:**<br><br>**(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.** |

| | |
|---|---|
| **ANALYSIS:** | Resident A eloped from the facility and was missing for four hours. Staff phone was turned down and could not hear the alarm. On date of incident, Resident A was exhibiting exit seeking behavior and appropriate interventions were not implements. Resident A's service plan notes that she has exit seeking behaviors. Resident was able to elope from the facility and found four hours later. Therefore, this claim was substantiated. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**ALLEGATION:**

**The incident was not reported to the State.**

**INVESTIGATION:**

The complaint alleged that they don't believe that the incident was reported.

Incident report with a timeline of the incident was sent to licensing consultant Aaron Clum. The reported read, investigation for 9/3/2022 elopement of Resident A.

| **APPLICABLE RULE** | |
|---|---|
| **R 325.1924** | **Reporting of incidents, accidents, elopement.** |
| | **(3) The home shall report an incident/accident to the department within 48 hours of the occurrence.** |
| **ANALYSIS:** | The facility complied with this rule. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

## IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of the license remains unchanged.

04/26/2023

Brender Howard
Licensing Staff

Date

Approved By:

04/26/2023

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

Date