GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 1, 2023

Dawn Martin-Speese
Falco Corporation
Suite 101
5228 Lovers Lane
Portage, MI 49002

RE: License #: AM800015739
Investigation #: 2023A1031034
Allegan Enrichment Center #3

Dear Mrs. Martin-Speese:

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 (616) 356-0183.

Sincerely,
Kristy Duda, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

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

I. IDENTIFYING INFORMATION

License #:	AM800015739
Investigation #:	2023A1031034
Complaint Receipt Date:	04/10/2023
Investigation Initiation Date:	04/11/2023
Report Due Date:	06/09/2023
Licensee Name:	Falco Corporation
Licensee Address:	Suite 101 5228 Lovers Lane Portage, MI 49002
Licensee Telephone #:	(269) 342-8811
Administrator:	Dawn Martin-Speese
Licensee Designee:	Dawn Martin-Speese
Name of Facility:	Allegan Enrichment Center #3
Facility Address:	122 E. Delaware Street Decatur, MI 49045
Facility Telephone #:	(269) 423-7892
Original Issuance Date:	06/01/1994
License Status:	REGULAR
Effective Date:	09/01/2021
Expiration Date:	08/31/2023
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Staff did not provide appropriate supervision for Resident A and he eloped.	No
Resident B received the wrong medication.	Yes
Additional Findings	Yes

III. METHODOLOGY

04/10/2023	Special Investigation Intake 2023A1031034
04/11/2023	Special Investigation Initiated - Letter
04/18/2023	Contact - Documents Requested and Received.
04/25/2023	Inspection Completed On-site
04/25/2023	Contact - Face to Face Interviews completed with Layna Swink, Michelle Anderson, Jessie Miller, Alexandra Crawford, and Resident B.
04/28/2023	Contact - Documents Reviewed.
05/19/2023	Contact – Telephone Interview held with Tom Pabreza and Joel Parish.
06/01/2023	Exit Conference held with Licensee Dawn Martin-Speese

ALLEGATION:

Staff did not provide appropriate supervision for Resident A and he eloped.

INVESTIGATION:

On 4/18/23, I received an incident report stating Resident A eloped from the home on 4/15/23. Staff completed 15-minute checks on all residents and realized Resident A was not in the home. Staff went into the community in efforts to locate Resident A and he could not be located. The home contacted law enforcement to submit a missing person's report. Law enforcement and staff continued to make ongoing

efforts to locate Resident A. Efforts included contacting local shelters, hospitals, and jails. On 4/16/23, Resident A was located at a homeless shelter in Battle Creek, MI. The Program Coordinator Layna Swink picked up Resident A from the shelter and transported him home.

On 4/18/23, I requested Resident A's *AFC Assessment Plan, Resident Care Agreement,* and *Behavior Support Plan.* Resident A's *AFC Assessment Plan* indicates staff accompany Resident A in the community for health and safety reasons as needed. Resident A's *Behavior Support Plan* indicates he is a risk for unintended harm due to his elopement attempts and successful elopements. Resident A has a history of elopement and has hitchhiked to get places. Resident A has a diagnosis of dementia and had a blood clot in his lung and is prescribed blood thinners. The plan indicated that Resident A is to be supervised in the community at all times due to his vulnerability in the community and his worsening symptoms of dementia. The plan also indicates that staff should have a "general knowledge" of Resident A's whereabouts within the home and staff will accompany him in the community. The plan indicates if Resident A cannot be located after an elopement, to follow agency policy for a missing person within five minutes. The home is noted to be working with Resident A's case manager and behaviorist to determine if a change in his monitoring and supervision is needed for his continued health and safety.

On 4/25/23, I interviewed the Program Coordinator Layna Swink in the home. Ms. Swink reported she was not working when Resident A eloped but was on-call. Ms. Swink reported staff contacted her due to Resident A leaving the home during a shift change. Ms. Swink reported staff were completing 15-minute checks and noticed Resident A was not in the home. Staff immediately contacted her, and staff searched the community for him. Ms. Swink reported she directed staff to contact law enforcement to complete a missing person's report. Ms. Swink reported Resident A requires ongoing supervision and staff complete checks in the home for all residents every 15 minutes. Ms. Swink reported Resident A was located the next day in Battle Creek, MI and she picked him up and transported him home.

On 4/25/23, I interviewed Resident A in the home. Resident A reported staff check on him frequently and keep eyes on him. Resident A reported he "snuck out" of the home when staff turned around to go into another room. Resident A acknowledged that he is supposed to be supervised by staff when he leaves the home. Resident A reported he hitchhiked from Decatur, MI to Kalamazoo, MI and spent time at the homeless shelter. Resident A reported he hitchhiked again and went to a shelter in Battle Creek, MI.

On 4/25/23, I interviewed Direct Care Worker (DCW) Michelle Anderson in the home. Ms. Anderson reported she was not working when Resident A eloped. Ms. Anderson reported Resident A's supervision plan requires staff to have "eyes on him" at all times and to conduct checks every 15-minutes.

On 4/25/23, I interviewed DCW Jessie Miller in the home. Ms. Miller reported Resident A eloped right after shift change which was around 2pm. Ms. Miller reported she did not see Resident A when she initially entered the home around 2pm and assumed he was in his bedroom. Ms. Miller reported staff conducted 15-minute checks around 2:15pm and realized Resident A was not in the home. Ms. Miller reported staff searched for him and filed a missing person report. Ms. Miller reported Resident A requires staff to keep “eyes on him” and conduct checks every 15 minutes.

On 4/25/23, I interviewed DCW Alexandra Crawford in the home. Ms. Crawford reported she saw Resident A when she arrived at the home at 1:45pm. Ms. Crawford reported she then saw Resident A in the living room at 2pm. Ms. Crawford reported staff conducted 15-minute checks at 2:15pm and realized he was not in the home. Ms. Crawford reported staff checked the property and community and then filed a police report when he was not located. Ms. Crawford reported Resident A requires supervision in the community and they conduct 15-minute checks in the home.

On 4/28/23, I reviewed the home’s staff schedule on 4/15/23. The home had four staff working between the hours of 2pm and 6pm when Resident A eloped from the home.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	Based on interviews and the review of supporting documentation, it has been determined that the home had sufficient staff on duty to ensure the protection and supervision of Resident A. Resident A reported staff conduct checks on him frequently and he snuck out of the home when staff walked into another room. Resident A acknowledged that he is not supposed to leave the home without staff. The home had a 12:4 resident to staff ratio when Resident A eloped from the home. Resident A’s behavior plan for supervision indicates that Resident A is to have supervised community access and staff are to have a “general knowledge” of his whereabouts while in the home. Resident A was seen in the home at 1:45pm and 2pm; at 2:15pm he was not able to be located. Staff conduct 15-minute checks to provide additional

	supervision although this is not required per Resident A's behavior plans. The home reacted appropriately to the elopement and searched the community and filed a missing person report. The home has also contacted Resident A's case manager and behaviorist to assess if a new plan is needed to provide more supervision and monitoring.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident B received the wrong medication.

INVESTIGATION:

On 4/10/23, I received an incident report dated 4/7/23 stating Ms. Anderson passed the wrong controlled medication to Resident B. The report indicates Resident B received Lorazepam 1mg that belonged to another resident instead of his Clonazepam 0.5mg. Ms. Anderson completed three checks and compared the medication to the medication record. Ms. Anderson then sat the medication bubble pack down on the controlled medication box. Ms. Anderson then picked up the bubble pack and dispensed the medication. Ms. Anderson then realized she had grabbed the wrong bubble pack and had given Resident B the wrong medication. Ms. Anderson contacted the home manager who contacted Kalamazoo Long Term Pharmacy. The pharmacist reported that Resident B was previously prescribed the medication he received, and the medication was similar to his current medication. The home was instructed to monitor Resident B for side effects and if any side effects were observed to take him to the hospital. Corrective measures taken by the home included changing their medication process and keep controlled medication in a labeled bag for each resident and they are placed in individual slots. The home is also planning to have all direct care workers take a medication improvement class and they are developing an additional inhouse training that will focus on proper techniques on handling and passing medications. Ms. Anderson will also be required to complete three supervised medication passes before being allowed to pass medications independently.

On 4/13/23, I received training documentation for medication training for all staff in the home that was completed on 4/12/23.

Ms. Swink reported Ms. Anderson reported the medication error to her immediately. Ms. Swink reported Ms. Anderson informed her she gave Resident B the wrong medication due to grabbing the wrong bubble pack. Ms. Swink reported Ms. Anderson and all other staff received an in-service medication training following the

incident. Ms. Swink reported Ms. Anderson has worked at the home for over ten years and has not had any previous medication errors occur.

Ms. Anderson reported she was preparing Resident B's medication and compared his medication to the medication record. Ms. Anderson reported she set the bubble pack on top of the other medications in the controlled medication box. Ms. Anderson reported she was having a conversation with Resident B and got distracted. Ms. Anderson reported she then mistakenly picked up the wrong medication pack and administered the medication. Ms. Anderson admitted she did not conduct one final check before giving the medication to Resident B. Ms. Anderson reported she reported the error to management immediately and has been pulled from passing medications and is being required to take additional training. Ms. Anderson reported Resident B did not have any negative side effects.

INVESTIGATION:

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Resident B was provided with another resident's medication which was not pursuant to label instructions. Ms. Anderson admitted to mistakenly passing Resident B the wrong medication due to being distracted when preparing medications and not conducting a final check before administering the medication. Ms. Anderson acknowledged her mistake and reported she will be receiving additional medication training.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

On 5/19/23, I interviewed Resident B's case manager Tom Pabreza via telephone. Mr. Pabreza reported Resident B has an extensive history of elopement. Mr. Pabreza reported Resident B's behavior plan and assessment plan need to be updated to reflect new levels of supervision needed especially due to the recent elopement. Mr. Pabreza reported he plans to reach out to the home to address the concerns involving Resident B's elopement needs.

On 5/19/23, I interviewed Resident B's behaviorist Joel Parish. Mr. Parish reported he was not aware of the recent elopement. Mr. Parish reported Resident B's elopement attempts have decreased due to a decline in his health and having

dementia. Mr. Parish reported there is a need to redevelop his plan based on his current health status and recent elopement. Mr. Parish reported he plans to make it a priority to reassess Resident B's supervision needs.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria**
	(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: **(a) The amount of personal care, supervision, and protection that is required by the resident is available in the home.**
For Reference: MCL 400.707	**Definitions; R to T.**
	(5) "Protection", subject to section 26a(2), means the continual responsibility of the licensee to take reasonable action to ensure the health, safety, and well-being of a resident, including protection from physical harm, humiliation, intimidation, and social, moral, financial, and personal exploitation while on the premises, while under the supervision of the licensee or an agent or employee of the licensee, or when the resident's assessment plan states that the resident needs continuous supervision.
ANALYSIS:	Resident A had a known history of elopements. The home was not able to reasonably protect Resident A from potential harm due to an inadequately developed plan of care regarding line-of-sight supervision.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15303	**Resident care;**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.

For Reference: R 400.14102	**Definitions.**
	(d) "Assessment plan" means a written statement which is prepared in cooperation with a responsible agency or person and which identifies the specific care and maintenance, services, and resident activities appropriate for each individual resident's physical and behavioral needs and well-being and the methods of providing the care and services, taking into account the preferences and competency of the individual.
ANALYSIS:	Resident A had a known history of elopements. His assessment plan did not adequately address the higher level of monitoring needed. Knowing the "general whereabouts", without defined expectations of staff, allowed for opportunities for him to leave unnoticed. While the home had been conducting 15-minute checks on Resident B as an extra precaution, this method was not listed in his plan and was not sufficient supervision to prohibit him from leaving unnoticed.
CONCLUSION:	**VIOLATION ESTABLISHED**

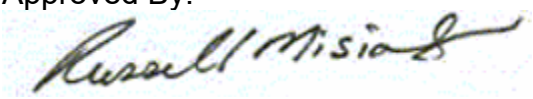
IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, it is recommended the status of the license remain unchanged.

5/19/23

Kristy Duda Date
Licensing Consultant

Approved By:



5/31/23

Russell B. Misiak Date
Area Manager