GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 29, 2023

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

RE: License #: AH170271455
Investigation #: 2023A1021063
Hearthside Assisted Living

Dear Tracey 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 #:	2023A1021063
Complaint Receipt Date:	05/26/2023
Investigation Initiation Date:	05/26/2023
Report Due Date:	07/25/2023
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 A eloped from the facility.	Yes
Additional Findings	No

III. METHODOLOGY

05/26/2023	Special Investigation Intake 2023A1021063
05/26/2023	Special Investigation Initiated - Telephone interviewed APS worker
05/31/2023	Contact - Telephone call made interviewed facility nurse
06/01/2023	Contact - Document Received received resident chart documents
06/08/2023	Contact - Telephone call made interviewed Staff Person 1
06/08/2023	Contact - Telephone call made interviewed Staff Person 2
06/08/2023	Contact - Telephone call made interviewed Staff Person 3
06/12/2023	Contact-Document Received Received 30 minute check documentation
06/29/2023	Exit Conference

ALLEGATION:

Resident A eloped from the facility.

INVESTIGATION:

On 05/26/2023, the licensing department received a complaint from Adult Protective Services (APS) that Resident A eloped from the facility.

On 05/26/2023, I interviewed APS worker David Jones by telephone. Mr. Jones reported Resident A eloped from the facility on 04/28/2023. Mr. Jones reported Resident A was outside in the courtyard, moved a grill to open the gate, and then exited the property. Mr. Jones reported Resident A was found by a passerby at a nearby gas station. Mr. Jones reported Resident A eloped again on 05/01/2023 by following a staff member outside.

On 05/31/2023, I interviewed director of nursing Taylor Lee by telephone. Ms. Lee reported Resident A eloped from the facility on 04/28/2023. Ms. Lee reported Resident A was trying to leave the facility and a staff member brought her back to the outside courtyard as sometimes going outside will calm Resident A down. Ms. Lee reported Resident A moved a grill to open the gate and was able to exit the facility property. Ms. Lee reported Resident A got ¼ mile away and was gone no more than 20 minutes. Ms. Lee reported on 05/01/2023, Resident A again eloped from the facility. Ms. Lee reported Resident A followed a staff member out the door and was found at a nearby gas station. Ms. Lee reported Resident A got ½ mile away and was gone no more than 15 minutes. Ms. Lee reported for the first elopement, the wander guard system was not activated as Resident A was already outside. Ms. Lee reported Resident A can now not be left alone outside. Ms. Lee reported on the second occasion, the wander guard system did not alarm as the door was already open and Resident A was able to sneak out when the door was breached, and the alarm was not activated. Ms. Lee reported at times Resident A is very focused on leaving the facility. Ms. Lee reported when this occurs, staff will attempt to focus more attention on Resident A, if able. Ms. Lee reported Resident A has PRN Ativan that will also help. Ms. Lee reported a staff member did contact Resident A's PCP on potential medication adjustments, but the facility has not heard a response from the PCP.

On 06/08/2023, I interviewed staff person 1 (SP1) by telephone. SP1 reported on 04/28/2023, Resident A was sitting outside and was able to access the gate and leave the property. SP1 reported Resident A was gone no more than 20 minutes. SP1 reported the wander guard system was not activated as Resident A was already outside. SP1 reported Resident A can no longer be left alone outside. SP1 reported on 05/01/2023, she was leaving her shift and de-activated the front door alarm to exit the facility. SP1 reported Resident A moved her walker in front of the door to keep the door alarm inactivated. SP1 reported Resident A was able to get into the foyer unnoticed and was then able to exit the building. SP1 reported she did not see any residents leave with her. SP1 reported Resident A would wander away from her home and has behaviors of trying to leave the facility. SP1 reported Resident A does well with 1:1 attention but the facility can not always provide that. SP1 reported Resident A has PRN Ativan but if Resident A is very agitated, staff members can not get Resident A to take the medication.

On 06/08/2023, I interviewed SP2 by telephone. SP2 reported she was working the shift when Resident A eloped on 05/01/2023. SP2 reported she was completing 30-

minute checks on Resident A and observed Resident A to be missing from the facility. SP2 reported she looked for Resident A for 15 minutes and then contacted 911. SP2 reported Resident A is constantly trying to leave the facility. SP2 reported when this occurs staff members will get Resident A involved in activities and provide extra support to Resident A.

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

> *"Gets confused. Elopement Risk. Wander guard. Cannot sit in garden area w/o supervision. 30-minute checks."*

I reviewed 30-minute checks documentation for Resident A. The documentation revealed multiple dates and times when the 30-minute checks were not initialed that the checks were completed. Examples include but not limited to the following dates and time periods when no 30-minute checks were not completed:

> 5/3 2400-0630, 5/8 1530-2330, 5/9 1530-2330, 5/10 2400-0630, 05/11 2400-0630, 05/14 2400-0630, 05/20 1530-2330, 05/22 1530-2330.

I reviewed facility notes for Resident A. The notes read,

> *"04/12: 2300 when doing shift change supervisor on shift notified me resident has been pacing the hallways and refusing to go to bed. PRN melatonin given. 2330 resident again packing and attempting to leave assisted back into building and into recliner using wheelchair resident was attempting to slap pinch and bite staff. PRN lorazepam attempted resident refused. 0000 resident attempt to leave and was brought back inside with a wheelchair and assisted to bed.*
> *04/13/2023: Resident has been up all day enjoying the sunshine, she's been trying to go out the doors though.*
> *04/16/2023: Resident had an Ativan @0930 for continuously going out the doors and getting combative with staff.*
> *04/27/2023: Ativan given at 1600 resident was on the hunt again trying to go outside, she claims she searching for a boyfriend. Resident calmed down after supper and has been up all day/afternoon. Melatonin given with hs meds.*
> *04/28/2023: Res refused her meds this morning very agitated. Fell asleep in the lobby for a couple hours and got up wanting to leave she did take a Ativan when other staff got her @1530.*
> *04/28/2023: Resident kept going out the front door entrance, an Ativan was given @1530 but resident continued to go out the door. About 1630 resident went out the door again and was redirected back inside and was brought to the fenced in garden area to sit there. At 1650 hearth side got a call that our resident was spotted by the recycling center. When staff arrived resident was sitting on her butt being assessed by paramedics, vitals within normal range and no signs of injuries.*
> *05/02/2023: resident eloped @2300 SS did 0000 room checks not able to find resident. SS and aids on shift searched the building and surrounding areas for 15*

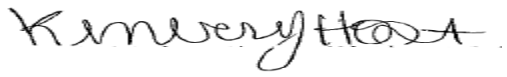
minutes before contacting 911 and Tracy Holt, SP3, and SP4. Officers found resident at a nearby gas station and resident was retuned at 0130 and evaluated by ems. SS attempted contact with guardian phone number was disconnected. Resident has small bruise on lower back was not taken to hospital by ems. No complaints of pain PRN melatonin and Ativan give upon arrival home.
05/15/2023: Resident was in and out the doors this afternoon, also her behavior was really odd. Kept inappropriately touching and bugging the male staff, laughing hysterically for no reason, making the most off the wall comments even if no one was engaging with her. Gave her an Ativan at 1920 resident was no longer attempting to go out the doors and her mental status was back to the norm but was still touchy.
05/22/2023: This afternoon resident kept going out the doors and being combative with staff that were trying to assist her back in. Gave Ativan @1800, helped resident a little. No attempts to go back outside after staff has sat with her outside for a good 20 minutes, but resident was still agitated and attempted to steal the break room radio thinking it's her purse.
05/24/2023: Resident was out the doors this afternoon, did not have the staff to sit with her, attempts were made to contact daughter. Resident took an Ativan at 1820 not much help by 1930 resident was still trying to go out the doors and being combative. Resident refused her HS meds.
05/25/2023: Res was very agitated this afternoon was going out all the doors hitting staff. Gave her a PRN Ativan at 1300. Res is sitting down now in lobby.
05/30/2023: gave res a Ativan at 1400 very agitated and going out the doors.
05/30/2023: Resident continued attempting to go out the doors up until after supper she begun to slow down for the night."

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.**
	(16) "Protection" means the continual responsibility of the home to take reasonable action to ensure the health, safety, and well-being of a resident as indicated in the resident's service plan, including protection from physical harm, humiliation, intimidation, and social, moral, financial, and personal exploitation while on the premises, while under

	the supervision of the home or an agent or employee of the home, or when the resident's service plan states that the resident needs continuous supervision.
ANALYSIS:	Resident A eloped from the facility on 04/28/2023 and on 05/01/2023. After the elopements, the facility implemented 30-minute safety checks and Resident A is no longer allowed outside unattended. The facility did contact Resident A's PCP on 05/02/2023, did not receive a response, and has not attempted again to connect with the PCP. Review of documentation and interviews conducted revealed Resident A is still confused and will voice the desire to leave the community. The facility has not implemented adequate practices to ensure the protection of Resident A. The facility lacks an organized program of supervision and reasonable protective measures to keep Resident A safe.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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



06/20/2023

Kimberly Horst Date
Licensing Staff

Approved By:

06/29/2023

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