GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

March 7, 2024

Tameka Stinson
Ivory house Care
18050 W Home Ave
Flint, MI 48504

RE: License #: AS250407706
Investigation #: 2024A0569020
Ivory house Care

Dear Tameka Stinson:

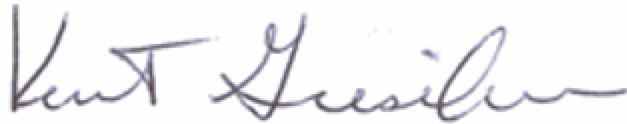
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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) 643-7960.

Sincerely,



Kent W Gieselman, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 931-1092

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS250407706
Investigation #:	2024A0569020
Complaint Receipt Date:	01/17/2024
Investigation Initiation Date:	01/17/2024
Report Due Date:	03/17/2024
Licensee Name:	Ivory house Care
Licensee Address:	18050 W Home Ave Flint, MI 48504
Licensee Telephone #:	(248) 416-9855
Administrator:	Tameka Stinson
Licensee Designee:	Tameka Stinson
Name of Facility:	Ivory house Care
Facility Address:	1805 W Home Ave Flint, MI 48504
Facility Telephone #:	(248) 416-9855
Original Issuance Date:	02/23/2022
License Status:	REGULAR
Effective Date:	08/23/2022
Expiration Date:	08/22/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident A has dementia and eloped from this facility on 1/15/24.	Yes
ADDITIONAL FINDINGS	Yes

III. METHODOLOGY

01/17/2024	Special Investigation Intake 2024A0569020
01/17/2024	APS Referral Complaint received from APS.
01/17/2024	Special Investigation Initiated - Telephone Attempted contact with complainant. Left voicemail.
02/27/2024	Inspection Completed On-site
02/27/2024	Inspection Completed-BCAL Sub. Compliance
02/27/2024	Contact - Document Received Email from Brandi Morris, APS.
02/27/2024	Contact- Telephone call made. Contact with Guardian.
02/27/2024	Exit Conference Exit conference with Tameka Stinson, licensee.
02/27/2024	Corrective Action Plan Requested and Due on 03/15/2024.
03/04/2024	Contact- document sent. Text message sent and received from Tameka Stinson, licensee.

ALLEGATION:

Resident A has dementia and eloped from this facility on 1/15/24.

INVESTIGATION:

This complaint was received from the adult protective services central intake department. The complainant reported that Resident A has dementia and eloped from this facility during the night on 1/15/24. The complainant reported that Resident A was found by police wandering outside with a blanket. The complainant reported that Resident A was then taken to the hospital for evaluation. The complainant reported that the staff were not aware that Resident A had eloped for several hours. The complainant reported that Resident A was treated and then returned to this facility.

Brandi Morris, APS worker, stated on 2/27/24 that she investigated this complaint. Brandi Morris stated that Resident A was able to walk out of the front door during a shift change on 1/15/24. Brandi Morris stated that Resident A was found by police and taken to the emergency room for treatment and evaluation. Brandi Morris stated that she did not substantiate abuse or neglect of Resident A.

An unannounced inspection of this facility was conducted on 2/27/24. Resident A was observed to be appropriately dressed and groomed with no visible injuries. Resident A has been diagnosed with dementia and was unable to give an accurate statement regarding this allegation. Resident A’s file was reviewed. Resident A’s written assessment documents that Resident A has been diagnosed with dementia. Resident A’s assessment does not indicate that Resident A has had any prior incidents of elopement. Resident A’s file documents that she has resided in this facility for two years.

Resident A’s guardian (Guardian) stated on 2/27/24 that Resident A has resided in this facility for two years and has never eloped from this facility prior to this incident. Guardian stated that Resident A spends every weekend with Guardian, so Guardian sees Resident A every week. Guardian stated that she has never observed Resident A to be neglected or improperly supervised in any way. Guardian stated that she has no concerns regarding Resident A’s care at this facility.

Shalita Thompson, staff person, stated on 2/27/24 that she is a live-in staff person and was the staff person present when Resident A eloped on 1/15/24. Shalita Thompson stated that Resident A had been restless during the evening on 1/14/24 and did not go to bed until around 1:00am. Shalita Thompson stated that she stayed up until Resident A went to bed and waiting until she was sure that Resident A had fallen asleep. Shalita Thompson stated that she then went to bed. Shalita Thompson stated that she thought that she had locked the front door of the facility and that she had turned the door alarm on, but actually did not. Shalita Thompson stated that sometime during the night Resident A got up and had walked out the front door, but she was not aware because the alarm did not activate. Shalita Thompson stated that the next staff person then

came into the facility at around 6:00am and woke her up because Resident A was not in her bed. Shalita Thompson stated that Resident A will sometimes go into other residents’ bedrooms or into the garage. Shalita Thompson stated that she immediately checked the facility and did not find Resident A. Shalita Thompson stated that she then looked around the facility outside and did not find Resident A. Shalita Thompson stated that the police were called to report Resident A missing. Shalita Thompson stated that the police then notified her that Resident A had been found and taken to the emergency room for evaluation. Shalita Thompson stated that Resident A was treated and released back to the facility. Shalita Thompson stated that Resident A had not eloped from the facility prior to this. Shalita Thompson stated that Resident A’s physician was notified, and Resident A’s medications have been adjusted. Shalita Thompson stated that Resident A does not wander around the facility since her medications were adjusted. Shalita Thompson stated that staff are also more careful about locking the door and turning the alarm on.

Tameka Sinson, licensee designee, stated on 2/27/24 that she was notified by staff on 1/15/24 that Resident A had eloped, but was found by police and taken to the emergency room for evaluation. Tameka Sinson stated that Resident A had not eloped prior to or since this incident. Tameka Sinson stated that she believes that Resident A eloped through the front door around 3:15am on 1/15/24 and that the door had not locked all the way. Tameka Sinson stated that law enforcement was called, and Resident A had been found by police and taken to the hospital. Tameka Sinson stated that she reviewed with all of the staff that the door has to be checked to insure it is locked at night and the door alarms must be turned on as well. Tameka Sinson stated that Resident A’s physician has adjusted her medications, and that Resident A has not exhibited the restless and wandering behaviors as frequently.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Tameka Sinson and Shalita Thompson both stated that Resident A was able to elope from this facility during the night of 1/15/24. Resident A has been diagnosed with dementia and not able to give a reliable statement regarding this allegation. From the statements given, Resident A eloped sometime after

	1:30am, and staff were not aware of Resident A's absence until 6:00am. Based on the statements given, it is determined that there has been a violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Resident A's file was reviewed during the inspection on 2/27/24. Resident A's file did not contain an incident report documenting the elopement and hospitalization on 1/15/24.

Shalita Thompson stated on 2/27/24 that she did document the incident by "writing it down on a note pad". Shalita Thompson stated that she did not complete an accident/incident record documenting the incident.

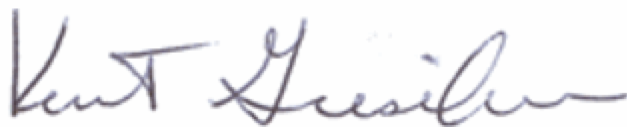
Tameka Stinson, licensee, stated on 3/4/24 that staff wrote the incident down "as a note". Tameka Stinson stated that the information was not transferred to an incident report, but she will have staff complete the report.

APPLICABLE RULE	
R 400.14311	**Incident notification, incident records.**
	(**3) An incident must be recorded on a department-approved form and kept in the home for a period of not less than 2 years.**
ANALYSIS:	Resident A's file did not contain an incident report documenting the elopement and hospitalization on 1/15/24. Tameka Stinson and Shalita Thompson stated that the incident was documented as a note, but that an incident report was not completed. Based on the observations made and statements given, it is determined that there has been a violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

An exit conference was conducted with Tameka Stinson, licensee designee, on 2/27/24 and 3/5/24. The findings in this report were reviewed and a corrective action plan was requested.

IV. RECOMMENDATION

I recommend that the status of this license remain unchanged with the receipt of an acceptable corrective action plan.



3/5/2024

Kent W Gieselman   Date
Licensing Consultant

Approved By:

3/7/2024

Mary E. Holton   Date
Area Manager