STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

MARLON I. BROWN, DPA
DIRECTOR

May 28, 2024

Dolanda Scott
Anthology of Farmington Hills
30637 W 14 Mile Rd
Farmington Hills, MI 48334

RE: License #: AH630402476
Investigation #: 2024A1019053

Dear Licensee:

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. Failure to submit an acceptable corrective action plan will result in disciplinary action. 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.

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,

Elizabeth Gregory-Weil, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 347-5503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630402476
Investigation #:	2024A1019053
Complaint Receipt Date:	05/08/2024
Investigation Initiation Date:	05/09/2024
Report Due Date:	07/07/2024
Licensee Name:	CA Senior Farmington Hills Operator, LLC
Licensee Address:	130 E Randolph St, Suite 2100 Chicago, IL 60601
Licensee Telephone #:	(312) 994-1880
Administrator and Authorized Representative:	Dolanda Scott
Name of Facility:	Anthology of Farmington Hills
Facility Address:	30637 W 14 Mile Rd Farmington Hills, MI 48334
Facility Telephone #:	(248) 983-4780
Original Issuance Date:	03/30/2022
License Status:	REGULAR
Effective Date:	09/30/2023
Expiration Date:	09/29/2024
Capacity:	120
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A left the facility without supervision.	Yes
Additional Findings	No

III. METHODOLOGY

05/08/2024	Special Investigation Intake 2024A1019053
05/09/2024	Comment Complaint was forwarded to LARA from APS. APS denied the referral and is not investigating.
05/09/2024	Special Investigation Initiated - Face to Face
05/09/2024	Inspection Completed On-site
05/09/2024	Inspection Completed BCAL Sub. Compliance
05/14/2024	Contact- Document Sent Request made to Farmington Hills PD for copies of police reports.
05/21/2024	Contact- Document Received Police reports received.

ALLEGATION:

Resident A left the facility without supervision.

INVESTIGATION:

On 5/8/24, the department received a complaint that alleged Resident A eloped the facility on 5/6/24 and 5/7/24 without staff knowledge. The complainant is concerned that Resident A is not properly supervised.

On 5/9/24, I conducted an onsite inspection. Administrator and authorized representative Dolanda Scott was not present, but she was interviewed via phone and Employee 1 was also interviewed onsite. Ms. Scott and Employee 1 reported

that Resident A moved in on 4/30/24 as a respite stay while her husband is traveling overseas. Ms. Scott and Employee 1 reported that Resident A is very high functioning and can complete all personal care tasks and activities of daily living independently, however she suffers from dementia and requires supervision out in the community. Ms. Scott and Employee 1 both affirmed that Resident A eloped form the facility on 5/5/24 and 5/6/24, citing that Resident A understand that the memory care doors unlocked after holding down the cross bar for 15 seconds. Ms. Scott and Employee 1 reported that the door locks and alarm system were functioning properly, but that Resident A was able to outrun staff and get away.

While onsite, I reviewed Resident A's pre-move in assessment and incident reports for the elopements. Regarding Resident A's elopement risk, the pre move in assessment dated 4/29/24 read "*Resident currently wanders within the residence of the facility. May wander outside; health or safety may be jeopardized, but resident is cooperative when redirected to return. Resident requires supervision and intervention. May have behavior management plan in place.*"

The incident report for the first elopement read:

> *Writer seen [sic] resident approximal [sic] 5 minutes before noticing resident was not walking around Virtue common area w/peers. Writer immediately went to resident room to check to see if she was in there. Resident was not in the room and staff immediately checked all rooms, stairwells, floors and outside premises. 911 was initiated. Writer notified DOV and ED. Writer notified resident spouse and left voicemail. Message left for PCP.*

The incident report for the second elopement read:

> *Writer was walking behind resident and resident opened virtue exit door and begin [sic] to run out the door. Writer attempted to stop the resident but resident pushed writer and ran down the main street down the sidewalk. Writer proceeded to run behind resident. Writer contacted DOV made her aware of the incident. DOV, NOD, DHW, ED and staff proceeded to look for resident. Resident was found safe and brought back to community safe by ED. 911 was initiated. Resident was taken to hospital to get psych evaluation. EMT sent with face sheet and med list. POA made aware via voicemail.*

On 5/21/24, I obtained copies of the police reports for Resident A's elopements. The redacted report dated 5/5/24 read *"Last seen 10 minutes ago. Last time she was just outside but staff does not see her. No phone…Located [Resident A] walking Northwestern Hwy and Highview/ turned over to director of Anthology Dolanda Scott."* The redacted report dated 5/6/24 read in part:

> *Responded to the area of 14 Mile and Northwestern to check the area for [Resident A] who [redacted] from the facility with an approximate 10-15 minute time delay, last seen walking east on 14 Mile. Upon arriving in the area of 14 Mile*

and Middlebelt, I observed [Resident A] running on the north side of 14 Mile, heading west with her cell phone in hand. I made contact with [Resident A] and asked what she was doing… I explained that this was the second time I spoke with her in two days about leaving the facility unannounced… I advised [Resident A] not to leave the facility and that people are out looking for her out of concern. Moments later, Director Dolanda Scott arrived at which point [Resident A] entered Dolanda's vehicle to return to Anthology. I spoke with Dolanda and inquired how this can be prevented since this was the second day in a row that [Resident A] left the facility and police were needed to be called to help find her.

Another redacted police report from 5/13/24 was provided that outlined a third elopement that the department was unaware of. The report indicated that Resident A had returned to the facility with staff redirection and did not require police intervention.

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	**(p) "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.** **(u) "Supervision" means guidance of a resident in the activities of daily living, and includes all of the following:** **(iv) 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 A had three successful elopements that occurred within a short amount of time (5/5/24, 5/6/24 and 5/13/24). Facility staff provided inadequate supervision to Resident A, placing her at significant risk of harm when outside unattended.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon approval of an acceptable corrective action plan, I recommend no changes to the status of the license at this time.

05/21/2024

Elizabeth Gregory-Weil Date
Licensing Staff

Approved By:

05/28/2024

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