RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

June 20, 2018

Jennifer Alexander
Arrowhead Manor, LLC
5269 Navajo Trail
Pinckney, MI 48169

RE: License #: AS470386846
Investigation #: **2018A0584006**
Arrowhead Manor, LLC

Dear Ms. Alexander:

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.

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 (313) 456-0360.

Sincerely,

Candace L. Pilarski

Candace Pilarski, Licensing Consultant
Bureau of Community and Health Systems
Phone: (517) 284-8967
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS470386846
Investigation #:	2018A0584006
Complaint Receipt Date:	05/25/2018
Investigation Initiation Date:	05/29/2018
Report Due Date:	07/24/2018
Licensee Name:	Arrowhead Manor, LLC
Licensee Address:	5269 Navajo Trail Pinckney, MI 48169
Licensee Telephone #:	(810) 569-4909
Administrator:	Ann Farnsworth
Licensee Designee:	Jennifer Alexander
Name of Facility:	Arrowhead Manor, LLC
Facility Address:	5269 Navajo Trail Pinckney, MI 48169
Facility Telephone #:	(810) 355-1536
Original Issuance Date:	04/11/2017
License Status:	REGULAR
Effective Date:	10/11/2017
Expiration Date:	10/10/2019
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED AGED TRAUMATICALLY BRAIN INJURED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
There are expired medications (2016, 2017) in the medication cart that are still being used.	No
Resident is a 2 person assist yet there is only 1 aid per shift.	No
Resident was extremely dehydrated, and staff were not allowed to send her to ER.	No
Additional Findings	Yes

III. METHODOLOGY

05/25/2018	Special Investigation Intake 2018A0584006
05/29/2018	Special Investigation Initiated - Telephone Spoke with Kari Nichols, Jackson/Livingston County Services Supervisor.
05/30/2018	Contact - Telephone call received Reporting source
05/31/2018	Inspection Completed-BCAL Sub. Compliance
05/31/2018	Contact - Face to Face Interview with Christy Thompson, house manager
06/01/2018	Exit Conference Phone call, message system full, sent email to Jennifer Alexander, licensee.

ALLEGATION:

There are expired medications (2016, 2017) in the medication cart that are still being used.

INVESTIGATION:

On 5/31/2018, I made an unannounced onsite inspection to the Arrowhead Manor. Christy Thompson, the house manager, answered the door and welcomed me inside. I told Ms. Thompson that our department received a complaint and that I needed to see the medication cart. The medication cart was locked prior to my inspection and Ms. Thompson used a key to open the cart so I could look at the medication contents and the medications. Ms. Thompson provided me the book of medication logs used by staff to document medication passing. I reviewed every medication inside of all the medication cart drawers and found none that had an expired date.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	All of the medications found in the locked medication cart were not expired. The licensee maintains compliance with this rule to give medications according to label instructions.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident is a 2 person assist yet there is only 1 aid per shift.

INVESTIGATION:

With Ms. Thompson's assistance, the resident in the allegation was identified of the facility possible to need a 2 person assist who is referred to as Resident A for reporting purposes. I requested the resident file to review for Resident A. There was a past assessment from 2016 that noted a 2 person assist. Ms. Thompson stated she was working at this facility at that time (it was owned by a different licensee in 2016) and the assessment stated 2 person assist due to the resident having recent

surgery. Ms. Thompson stated after Resident A recovered from that surgery, she only requires one person to assist her currently when needed. The most recent assessment for Resident A does not specify that she requires a 2 person assist.

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:	Resident A is the only resident identified that would possibly need assistance due to using mobility devices such as a "sit to stand" and wheelchair. Currently Resident A is fully able to manage transferring with assistance with one person if needed. The current resident assessment does not indicate this resident must have two people to assist her. The licensee is meeting the rule requirement to provide services specified in the resident care agreement and assessment plan.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident was extremely dehydrated, and staff were not allowed to send her to ER.

INVESTIGATION:

With Ms. Thompson's assistance, the resident in the allegation was identified and is referred to as Resident B for reporting purposes. Resident B was recently treated for a urinary tract infection (UTI) with antibiotics. I reviewed Resident B's file for past medical issues and documentation. Resident B has a history of UTI medical issues. Ms. Thompson stated that Resident B is still currently out of the facility being treated for her dehydration and UTI issues and is planning on returning to the facility. Resident B was being reminded to drink plenty of fluids by the facility staff. Ms. Thompson said that they were monitoring Resident B's overall wellbeing and notified the family that it appeared that Resident B was not getting hydrated. The family was asked to get her to the doctor to be assessed. The family was not convinced it was necessary. Ms. Thompson stated that the next day, Resident B stated she did not feel very good, so she contacted the family again. The family was not responding so Ms. Thompson stated Resident B's doctor was contacted and the doctor suggested

to have Resident B seen immediately at the hospital. The facility staff contacted Emergency Medical Service (EMS) and Resident B was transported to the hospital.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	Resident B was closely monitored by staff for changes in her health due to recent treatment for an infection. Resident B's family was notified one day that it appeared Resident B's health was not optimal and appeared dehydrated. The staff were concerned about Resident B being dehydrated and documented the steps while observing her condition. Ms. Thompson stated the family takes Resident B to the doctor, were not taking steps to do so, and after consulting with Resident B's doctor, notified the family the facility is initiating medical care for Resident B. The facility manager, administrator, and licensee understand that if there is a change in health and wellbeing to have residents transported to the hospital if needed. The facility obtained needed care with the adverse change in health of Resident B to abide by the rule expectations.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

I found when reviewing two of the resident files, the resident care agreement was not updated as required. The last resident care agreement was dated March 2017 for both residents so was overdue for the required annual update by a few months.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(9) A licensee shall review the written resident care agreement with the resident or the resident's designated

	representative and responsible agency, if applicable, at least annually or more often if necessary.
ANALYSIS:	Two resident files did not have updated resident care agreements as required by the rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

During the investigation into allegations regarding Resident B, I found the facility did not send an incident report to the department alerting Resident B was sent to and admitted to the hospital. After discussing this violation with Ms. Thompson, an incident report for Resident B's illness and hospitalization was completed and submitted to me for the department's facility file.

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following: **(b) Any accident or illness that requires hospitalization.**
ANALYSIS:	The facility did not send an incident report on the hospitalization of Resident B within the required time frame. This is not in compliance with the rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, it is recommended that the status of the license remains unchanged.

June 14, 2018

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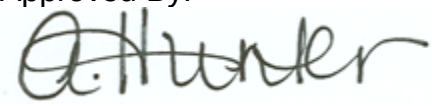
Candace Pilarski Date
Licensing Consultant

Approved By:



June 20, 2018

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Ardra Hunter Date
Area Manager