GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 26, 2021

Dionissia Sinning
The Arbor Inn
14030 E Fourteen Mile Rd.
Warren, MI 48088

RE: License #: AH500236728
Investigation #: 2022A0585011
The Arbor Inn

Dear Ms. Sinning:

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) 284-9730.

Sincerely,

Brender L. Howard

Brender Howard, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(313) 268-1788
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH500236728
Investigation #:	2022A0585011
Complaint Receipt Date:	11/18/2021
Investigation Initiation Date:	11/18/2021
Report Due Date:	01/18/2021
Licensee Name:	The Warren Arbor Co.
Licensee Address:	14030 E 14 Mile Rd. Warren, MI 48088
Licensee Telephone #:	(586) 296-3260
Authorized Representative/Administrator:	Dionissia Sinning
Name of Facility:	The Arbor Inn
Facility Address:	14030 E Fourteen Mile Rd. Warren, MI 48088
Facility Telephone #:	(586) 296-3260
Original Issuance Date:	06/01/1999
License Status:	REGULAR
Effective Date:	01/28/2021
Expiration Date:	01/27/2022
Capacity:	138
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Staff was observed working in the area of Resident A where she was restricted to be due to past abuse.	Yes
Additional Findings	No

III. METHODOLOGY

11/18/2021	Special Investigation Intake 2022A0585011
11/18/2021	Special Investigation Initiated - Telephone Contacted the complainant regarding the allegations.
11/18/2021	APS Referral Made a referral to Adult Protective Services (APS).
12/03/2021	Inspection Completed On-site Completed with observation, interview and record review.
12/03/2021	Inspection Completed – BCAL Sub. Compliance
12/09/2021	Contact - Telephone call made Called the administrator Dion to request documents.
12/15/2021	Contact - Telephone call made Call administrator to get additional documents and to discuss allegations.
12/20/2021	Contact - Document Received Requested documents received.
01/26/2022	Exit conference Conducted with authorized representative Dionissia Sinning.

ALLEGATION:

Staff was observed working in the area of Resident A where she was restricted to be due to past abuse.

INVESTIGATION:

On 11/18/21, the department received the allegations from a complainant via the BCHS Online Complaint website.

On 11/18/21, a referral was made to Adult Protective Services (APS).

On 11/18/21, I spoke to the complainant by telephone. She stated that Resident A's authorized representative was visiting Resident A at the facility. She stated that staff by the name of Employee A came in the room and yelled at him saying that he was not supposed to be in there. She stated whenever Employee A is around, it triggers Resident A. She stated that Employee A is not supposed to have contact with Resident A.

On 12/3/21, I completed an onsite at the facility. At the time of the onsite, administrator Dionissia Sinning was not at the facility. I interviewed office manager Fran Depalma. She stated that Ms. Sinning would be back in the office next week and she would assist me in my investigation. She stated that APS worker came to the facility for the same incident. She stated that she did not know the specifics of the incident.

On 12/9/21, I interviewed Ms. Sinning regarding the incident. She stated that staff member Employee A was taken away from working with Resident A. She stated that the incident occurred a while ago and stated that Employee A was not to have any more contact with Resident A. She stated that Resident A's authorized representative reported that he was in the Resident A's room when Employee A yelled at him that he was not supposed to be in there. Ms. Sinning stated that the authorized representative was upset because Employee A was not to have any contact. She stated that it upset Resident A because she never forgot about the incident that happened a while ago. She stated that there have been no other complaints regarding Employee A. She stated that Employee A had training that included Resident Rights and Abuse.

On 12/15/21, additional request was made for additional information.

On 12/20/21, I received documents from Ms. Sinning that included, Resident A's service plan, and Resident A progress notes.

Ms. Sinning sent me an email that read,

> "*The original incident took place on 7/7/2020, shortly thereafter Employee A was taken off passing meds to her [Resident A]. We were 4 months into COVID, all the residents were isolated in their rooms and very upset about it, and we were very short staffed over worked and scared. I am not trying to make excuses, but I know Employee A would never abuse any of our residents. Her bedside manner is not the best, she is quick to right a wrong and not in a warm and*

friendly kind of way, she also does not like to admit to her mistakes. When I spoke to you on the phone, I told you about the 11/17/21 event with Resident A's authorized representative, he was visiting in her room with her roommate present, Employee A stopped and told him "You can't be in here" we have posted signs, we have sent it out in our newsletter, no visiting in semi-private rooms they must go to one of our dayrooms. He came directly up to my office and complained she was rude, she didn't even say "hello", just "you can't be in here". I apologized and explained to him about the visiting policy claims he didn't know. Employee A of course denied being rude, was told again to stay away from this resident and family."

In two letters, one not dated and the other dated 7/9/20 sent to management read,

First letter:

Dear Management of concern for [Resident A]. My brother text me at 10:20 p.m. Thursday that he talked to Resident A last night and she told him that the nurse that gives her medication every day has been very rude and talks back in a bad tone of voice. He said [Resident A] told the nurse when she upset her to go to hell, and nurse responded by saying "your mama". This been going on for a good while. Also, [Resident A] told my brother this nurse hit her on the back twice. I was visiting [Resident A] in her room and witness this nurse back talking [Resident A] right in front of me. I think she was very disrespectful toward Resident A] and I heard it from other residents she is very impolite. Something definitely needs to be done about this person ASAP.

Second Letter:

I had a complaint about this nurse before. [Resident A] is very nervous and she told me not to tell management because she scared this nurse that giver her meds daily might try to give her something in her meds to make her ill. This woman is unfriendly and never looks happy. It's bad enough that these seniors going through this epidemic and can't go to visit home to be there with their loved ones. She just makes residents more uncomfortable. Also, I would prefer someone else to give [Resident A] her meds.

A note written by Ms. Sinning, indicates that Employee A will no longer pass Resident A's medication and she fully understands she is to have zero contact with Resident A.

During the onsite, I observed Resident A in her room. She was well groomed, no distress noted. Resident A was approachable and was able to communicate in a friendly manner. She stated that some staff are nicer than others. She stated that staff "Employee A" was mean, and she did not want that staff to care for her or come in her room. She stated that the staff came in her room yelling.

The service plan for Resident A read, can make needs known; will need redirection as she adjusts to her new home. Reports can be sad with news and social issues, long drawn-out conversations, change topic. Easily redirected back on tract was reported. The plan read, loves to talk, she also worries about her peers. At times she will go off topic and began talking in circles about a brain tumor, spin herself in wheelchair, with hands up and begin to pray for others. Redirect if she becomes upset with you and you cannot resolve her needs as long as she is not at risk of harm to self or others. The best approach is to excuse yourself and reapproach later.

Training documents for Employee A notes that she had training for residents' rights and abuse.

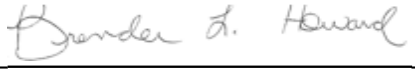
A note dated 11/15/21 read, Employee A suspended 11/9, 11/10 and 11/16. Employee signed statement that she understands to stay away from resident.

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 as organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.**
ANALYSIS:	The service plan gave instructions to redirect or walk away if not able to redirect if she is not at risk of harm to self or others. Employee A continues to be in the area where Resident A resides causing her to become upset despite getting instructions to stay away from the area. Facility did not keep Resident A safe by allowing staff to continue to be in the area. Therefore, the facility did not comply with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 1/26/2022, I shared the findings of this report with authorized representative Dionissia Sinning.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.



01/26/2022

Brender Howard — Date
Licensing Staff

Approved By:

01/25/2022

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