GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

Lou Petroni
The Arbor Inn
14030 E Fourteen Mile Rd.
Warren, MI 48088

December 27, 2022

RE: License #: AH500236728
Investigation #: 2022A1022014
The Arbor Inn

Dear Lou Petroni:

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.
- Be signed and dated.

Please review the enclosed documentation for accuracy and contact me with any questions.

Sincerely,

Barbara P. Zabitz, R.D.N., M.Ed.
Health Care Surveyor
Health Facility Licensing, Permits, and Support Division
Bureau of Community and Health Systems
Department of Licensing and Regulatory Affairs
Mobile Phone: 313-296-5731
Email: zabitzb@michigan.gov

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH500236728
Investigation #:	2022A1022014
Complaint Receipt Date:	07/21/2022
Investigation Initiation Date:	07/21/2022
Report Due Date:	08/20/2022
Licensee Name:	The Warren Arbor Co.
Licensee Address:	14030 E 14 Mile Rd. Warren, MI 48088
Licensee Telephone #:	(586) 296-3260
Administrator:	Fran DePalma
Authorized Representative:	Lou Petroni
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:	01/28/2022
Expiration Date:	01/27/2023
Capacity:	138
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
The facility informed the family that family members would need to provide overnight care for the Resident of Concern (ROC).	Yes
The care staff did notice that the ROC became unresponsive as she sat in the dining area.	No

III. METHODOLOGY

07/21/2022	Special Investigation Intake 2022A1022014
07/21/2022	Special Investigation Initiated - Telephone Spoke with complainant
08/05/2022	Inspection Completed On-site
08/05/2022	APS Referral
12/27/2022	Exit Conference

ALLEGATION:

The facility informed the family that family members would need to provide overnight care for the Resident of Concern (ROC).

INVESTIGATION:

On 7/21/2022, I interviewed the complainant by phone. The complainant stated that the family of the Resident of Concern (ROC) had been told that the facility had a rule that all residents must be in their rooms each night at 8 pm and were not to leave until 8 am. The ROC would not do that, and facility staff told the family that they would be responsible for keeping the ROC in her room. According to the complainant, either he or one of the ROC's sisters stayed with the ROC overnight, providing all of her evening care. The complainant did not know the date that the family was informed of this "rule," but that there had been an incident when the ROC scratched one of the caregivers that caused the staff to be "hands-off." The complainant then clarified that this applied only to care needed after 8 pm, because the staff did come to help his sisters bathe the ROC during the day.

On 8/5/2022, a referral was made to Adult Protective Services.

On 8/5/2022, during the onsite visit, I interviewed the administrator and the interim director of healthcare. Both the administrator and the director of health care agreed that the ROC displayed behaviors that made taking care of her challenging although she did not need a great deal of care. Both agreed that family members spent the night in the ROC's room, but both stated that it was the family's choice to stay. When asked about the idea that residents needed to stay in their rooms after 8 pm, the administrator stated that residents did not have "a bedtime."

Review of the ROC's admission contract, dated 3/22/2022 and signed by the complainant revealed that the facility had a "Resident Sitter Policy." According to this policy:

- It is the policy of the Arbor Inn to required alternate placement for a resident if a resident is exhibiting violent/inappropriate behaviors, has eloped from the building or is a significant fall risk.
- The Arbor Inn will provide one-on-one care for a maximum of 24 hours at a cost of $25.00/hr.
- After the 24-hour period, the responsible party must do one of the following until alternate placement is found
    - Contract one-on-one from a private duty agency
    - Provide one-on-one care themselves
    - Take the resident home with the responsible party

According to the ROC's service plan, the ROC was not an elopement risk and did not display aggressive or combative behaviors. The service plan indicated that the

“resident sometimes cry, will pace the memory care (MC) unit, give the resident activities to keep busy, can be distracted.”

The following progress note entries related to behavior from the ROC’s health record were found:

- On 3/25/2022, the day after the ROC was admitted to the facility, “resident aide (caregiver) tried to wake her up…for breakfast she tried to hit the resident aide…”
- On 3/27/2022, “…resident attacked [caregiver name] who was trying to get some bags from resident that she took off the cart. Resident some how opened the secure door (from the MC unit) and got out (of the MC unit).
- On 3/28/2022, “…the resident aide tried to wake her (the ROC) up and she wouldn’t…even tried to hit her resident aide.”
- On 4/11/2022, “…resident has been agitated when approached. Writer called [name of complainant] resident’s brother and asked for assistance…”
- On 4/12/2022, the entry reflected that the ROC was seen by an outside contracted psychiatric service provider who recommended changes to the ROC’s medication regimen.
- On 5/13/2022, the entry again reflected that the ROC was seen by the contracted psychiatric service provider.

There were no additional behavior related entries in the record.

According to the ROC’s service plan, the ROC was not independent for all activities of daily living (ADLs). The ROC required “total assistance with dressing/grooming,” “needs to have teeth brushed,” and “needs assistance with all personal hygiene and grooming.” At the time of the onsite visit, the administrator was asked how the facility managers knew whether or not the care that was noted on the service plan was provided to the resident. According to the administrator, care staff were to put a notation into their electronic medication administration record (EMAR). But when the administrator was asked to provide the documentation indicating that the ROC received these services in the evening, the administrator stated, “We do not put ADLS on our EMAR system the exception of Depend (brief brand) checks, treatments ordered by the physician and their shower day.”

Review of the ROC’s health record progress notes revealed that there was only one occasion when the ROC was provided care after the dinner meal: On 3/26/2022 at 3:34 am when a caregiver warmed up food from dinner for the ROC. Additionally, the incident of aggressive behavior on 3/27/2022 occurred at 1:15 am.

When the administrator was asked who in the facility would have the authority to require the family to stay overnight to provide that “one-to-one” care for the ROC, the administrator claimed to have no knowledge of how this came to be, and stated that a previous director of healthcare who no longer worked for the facility must have spoken to the family but failed to document the conversation or to place any entries on the service plan. The administrator then asserted that because the complainant

had signed the facility's "Resident Sitter Policy" at the time of the ROC's admission, that amounted to an agreement to voluntarily provide the one-to-one care for the ROC. The administrator was not able to explain how the "Resident Sitter Policy" was implemented.

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: R325.1901	**Definitions.**
	(4) "Assistance" means help provided by a home or an agent or employee of a home to a resident who requires help with activities of daily living.
ANALYSIS:	There was no evidence that the facility had determined that the ROC required an "alternate placement" due to behavior as required by their "Resident Sitter Policy," for example, the issuance of a 30-day discharge notice. There is no evidence that the ROC's family was asked to choose one of the three alternatives listed in the policy. There is no evidence that the facility provided any assistance to the ROC after the dinner meal.
CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION:

The care staff did notice that the ROC became unresponsive as she sat in the dining area.

INVESTIGATION:

According to the complainant, on 5/8/2022, when he arrived to the facility at 8 pm, he found the ROC seated in the dining room, slumped over onto a table. The complainant stated that another resident informed him that the ROC had been sitting like that “all day.” The complainant went on to say that although care staff members were in the room and acknowledged that the ROC had been there since they began their shifts at 3:30 pm, no one had done anything for her. After he unsuccessfully tried to get the ROC to stand, he went to the care staff and insisted that they call 911 and get the ROC to a doctor, as he suspected she had sustained a stroke.

At the time of the onsite visit, the interim director of healthcare stated that the ROC would frequently sit in the MC dining room, with her head down on the table and her eyes closed, as if she were asleep. The ROC would frequently not respond to someone speaking to her but might respond if someone touched her on her arm or on her back. During the time that the ROC lived in the facility, the interim director of healthcare was employed at the facility as a caregiver/supervisor and was on-duty on the day that the ROC was taken to the hospital. The director of healthcare stated that during the evening shift on 5/22/2022, the complainant came to her and asked that the ROC be sent out to the hospital. When the director of healthcare asked the complainant why, the complainant replied that the ROC was “worse than usual.” The director of healthcare then reported that she went to the ROC, who was sitting at a table with her head down, as she was known to do. The director of healthcare then stated that she touched the ROC’s arm in an attempt to rouse the ROC but was unsuccessful. “Even when I tried to lift up her eye lid, she (the ROC) didn’t respond.” The director of healthcare said that at point, she called 911.

The ROC’s health record progress notes dated 5/22/2022 confirmed that on that day, the ROC was sent to the hospital due to “physical and mental status change.” The ROC did not return to the facility. Although the complainant alleged that the incident occurred on 5/8/2022, the documentation indicated that he was incorrect about the date.

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.
ANALYSIS:	There was not any evidence that the behavior displayed by the ROC on 5/22/2022 was markedly different than her usual behavior, and not enough for the care staff to become alarmed.
CONCLUSION:	VIOLATION NOT ESTABLISHED

On 12/9/2022, the authorized representative gave permission for the exit conference to be conducted with the administrator. On 12/27/2022, I reviewed the findings with the administrator. When asked if there were any comments or concerns with the investigation, there were none.

IV. RECOMMENDATION

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

12/27/2022

Barbara Zabitz Date
Licensing Staff

Approved By:

12/06/2022

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