GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 1, 2023

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

RE: License #: AH500236728
Investigation #: 2023A1019050
The Arbor Inn

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 #:	AH500236728
Investigation #:	2023A1019050
Complaint Receipt Date:	06/13/2023
Investigation Initiation Date:	06/14/2023
Report Due Date:	08/13/2023
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:	136
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was assaulted by Resident B.	Yes
Additional Findings	Yes

III. METHODOLOGY

06/13/2023	Special Investigation Intake 2023A1019050
06/14/2023	Special Investigation Initiated - Letter Emailed APS worker for additional information and status update, correspondence is ongoing.
06/28/2023	Inspection Completed On-site
06/28/2023	Inspection Completed-BCAL Sub. Compliance
06/30/2023	Contact- Document sent Facility administrator was not able to provide all requested documentation and/or information to licensing staff onsite. Email follow up sent requesting status update on the outstanding request. Correspondence is ongoing.
07/05/2023	Contact- Telephone call TEAMs call held with area manager Andrea Moore, licensing staff Elizabeth Gregory-Weil, administrator Fran DePalma and authorized representative Lou Petroni.

ALLEGATION:

Resident A was assaulted by Resident B.

INVESTIGATION:

On 6/13/23, the department received a complaint forwarded from Adult Protective Services (APS) that reported Resident A had been hospitalized following a physical attack on her by Resident B. There are concerns that there was a lack of supervision when the incident occurred.

On 6/28/23, I conducted an onsite inspection. I interviewed administrator Fran DePalma. Ms. DePalma confirmed that Resident B attacked Resident A after Resident A had wandered into Resident B's apartment in the early morning of 6/7/23. Ms. Depalma stated she was not present at the time of the incident, but reported that the following is what she was told occurred:

- Employee 1 heard Resident A scream and ran to see what was happening.
- Employee 1 saw Resident A inside of Resident B's apartment. Resident A was being hit and stomped on.
- Employee 1 went to get help from Employee 2.
- 911 was called and dispatched to the facility.
- Resident A was taken to the hospital.

Ms. DePalma stated that police did not take Resident B into custody when they responded to staff's 911 call and stated that he was petitioned to the hospital later that same day. Ms. Depalma stated that Resident B was issued a 24-hour discharge notice and moved out of the facility on 6/8/23. Ms. DePalma was unaware of Resident A's medical disposition but stated that her family moved her belongings out of the facility on 6/14/23.

While onsite, incident report documentation was obtained regarding this incident. The incident report for Resident A read "Resident walked into another resident apartment and he assaulted her/ per shift supervisor". Two incident reports were completed on Resident B. The first report read "Resident physically assaulted another resident for going into his apartment. Family notified. 911 was called." The second report read "Resident assaulted another resident by hitting and kicking her when she was on the ground. This happened earlier this morning as a result this resident will be petitioned out for psych eval."

Ms. DePalma stated that Residents A and B resided in memory care, which had nine residents at the time of the incident and one staff working during third shift on the date in question. Ms. DePalma stated that both Residents were new to the facility, with Resident A having moved in on 5/30/23 and Resident B having moved in on 5/9/23. When questioned about details such as how long Resident A was in Resident B's apartment and when staff last saw Resident A before the attack, Ms. DePalma could not answer the question. Ms. DePalma stated that the facility has video surveillance in common areas, however she had not reviewed the footage to determine the timeline of events. Ms. DePalma stated that she had not interviewed Employee 1 or Resident B about what occurred.

I requested to review the surveillance footage from around the time that the attack occurred. Ms. DePalma and I reviewed the footage from the memory care unit several times and the following were observed:

- Resident A is seen wandering the hallways of the memory care unit for more than two hours prior to entering Resident B's apartment.

- Resident A enters other resident apartments throughout the time she is wandering the hallways of the memory care unit that night without staff intervention to deter the behavior.
- Between 2:00-2:02am, Employees 1 and 2 are seen walking past Resident A in the hallway but did not appear to attempt to redirect her back to her apartment.
- At 3:40am, Resident A is seen entering Resident B's apartment.
- At 3:43am, Employee 1 is seen entering Resident B's apartment, immediately running out of Resident B's apartment, and leaving the memory care unit.
- At 3:46am, Resident B is seen dragging Resident A out of his apartment and then returning to his apartment. Resident A is left lying in the hallway of the memory care unit, unattended to by staff.
- At 3:59am, Employee 1 returns to the memory care unit. She is seen standing at the far opposite end of the hallway from where Resident A was laying. She was not tending to Resident A or interacting with her in any way. Resident A can be seen on the ground in view.
- At 4:01am, police enter memory care unit and are seen standing over Resident A outside of Resident B's apartment.
- At 4:06am, a second staff member, which Ms. Depalma could not identify, arrives on the memory care unit.
- At 4:08am, emergency medical personnel enter memory care unit and tend to Resident A.

Numerous phone calls and email exchanges between Ms. DePalma, authorized representative Lou Petroni and the department were conducted following the onsite visit. Mr. Petroni submitted additional video footage from other camera angles that showed staff outside of Resident B's apartment after Employee 1 went to get help, however the videos do not show staff actually entering or exiting Resident B's apartment in an attempt to intervene. What can be seen is all staff leaving the unit at 3:46am as Resident A is being drug into the hallway by Resident B. When questioned about staff's actions, Mr. Petroni replied:

> *According to what I see on the video, there were no staff members in the unit from 3:46 - 3:59 AM. [Employee 1] reentered at 3:59 to cover [Resident A] with a blanket.*
>
> *According to [Employee 2's] statement, she told [Employee 1] to stay in the unit but she didn't because she was scared to be back there with him [referring to Resident B]. It is no excuse but, in their defense, [Resident B] is a very tall man and he was threatening to them so I really can't blame them for not wanting to be there with him until the police arrived.*

During this time that staff were absent from the unit, other memory care residents were awake and observed throughout the halls. All memory care residents were completely unsupervised for a total of 13 minutes.

Email correspondence was conducted with APS worker Mia Alston following receipt of the complaint. Ms. Alston reported that Resident A sustained a brain hemorrhage and passed away on 6/30/23 from her injuries.

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents;**
	(1) A health facility or agency that provides services directly to patients or residents and is licensed under this article shall adopt a policy describing the rights and responsibilities of patients or residents admitted to the health facility or agency. Except for a licensed health maintenance organization, which shall comply with chapter 35 of the insurance code of 1956, 1956 PA 218, MCL 500.3501 to 500.3580, the policy shall be posted at a public place in the health facility or agency and shall be provided to each member of the health facility or agency staff. Patients or residents shall be treated in accordance with the policy.
For Reference MCL 333.20201	**2(l) A patient or resident is entitled to be free from mental and physical abuse and from physical and chemical restraints, except those restraints authorized in writing by the attending physician for a specified and limited time or as are necessitated by an emergency to protect the patient or resident from injury to self or others, in which case the restraint may only be applied by a qualified professional who shall set forth in writing the circumstances requiring the use of restraints and who shall promptly report the action to the attending physician. In case of a chemical restraint, a physician shall be consulted within 24 hours after the commencement of the chemical restraint.**
ANALYSIS:	Resident A sustained significant injury after entering Resident B's apartment without his permission.
CONCLUSION:	**VIOLATION ESTABLISHED**

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	**Definitions.**
	(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:** **(i) Reminding a resident to maintain his or her medication schedule in accordance with the instructions of the resident's licensed health care professional as authorized by section 17708(2) of the act, MCL 333.17708.** **(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:	The facility failed to provide adequate protection and supervision to Resident A and did not successfully intervene as she was being attacked. Furthermore, all memory care residents were left unsupervised and unprotected for a period of 13 minutes after Resident A's assault while Resident B was still present on the unit.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Documentation from the skilled nursing facility and hospital that Resident A was at prior to her admission to the facility outline that she exhibited wandering behaviors and presented a risk for elopement. Resident A's service plan dated 5/31/23 identified that she was an elopement risk and wore a wander guard bracelet. Review of Resident A's progress notes reveal that staff documented elopement attempts on 6/1/23 (two times), 6/2/23, 6/5/23, 6/6/23; in some cases, the resident had gotten out of the building. I also observed other instances of staff reporting that Resident A was pacing and running through the hallways.

The service plan lacked any information addressing redirection techniques when elopement and wandering behaviors occurred and failed to provide any instruction to staff of how often she should be monitored.

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(5) A home shall update each resident's service plan at least annually or if there is a significant change in the resident's care needs. Changes shall be communicated to the resident and his or her authorized representative, if any.
ANALYSIS:	Resident A was a known wanderer and had multiple elopement attempts from the building. Staff neglected to update her service plan to provide instruction on how to redirect her when she exhibited such behaviors and was void of instruction on how often she should receive safety checks.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(8) A home shall not retain a resident if the resident has harmed himself or herself or others, or has demonstrated behaviors that pose a risk of serious harm to himself or herself or others, unless the home has the capacity to manage the resident's behavior.

ANALYSIS:	Resident A's elopement and wandering behaviors, combined with her lack of safety awareness put her at significant risk of harm. Staff failed to demonstrate that they were able to safely manage her behavior.
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.

07/31/2023

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Elizabeth Gregory-Weil Date
Licensing Staff

Approved By:

08/01/2023

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