GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

October 10, 2023

Rochelle Lyons
Senior Living Arbor Grove, LLC
7927 Nemco Way, Ste 200
Brighton, MI 48116

RE: License #: AH290406205
Investigation #: 2023A1028081
Arbor Grove Assisted Living & Memory Care

Dear Rochelle Lyons:

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 I am not available, and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

Julie Viviano, Licensing Staff
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

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

I. IDENTIFYING INFORMATION

License #:	AH290406205
Investigation #:	2023A1028081
Complaint Receipt Date:	09/11/2023
Investigation Initiation Date:	09/12/2023
Report Due Date:	11/11/2023
Licensee Name:	Senior Living Arbor Grove, LLC
Licensee Address:	7927 Nemco Way, Ste 200, Brighton, MI 48116
Licensee Telephone #:	Unknown
Administrator:	Amanda Raglin
Authorized Representative:	Allison Freed
Name of Facility:	Arbor Grove Assisted Living & Memory Care
Facility Address:	1320 Pine Avenue, Alma, MI 48801
Facility Telephone #:	(989) 463-3074
Original Issuance Date:	06/02/2021
License Status:	REGULAR
Effective Date:	12/02/2022
Expiration Date:	12/01/2023
Capacity:	62
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Residents are neglected in memory care and staff do not follow service plans.	Yes
There only one care staff member on third shift in the memory care unit.	Yes
Additional Findings	Yes

III. METHODOLOGY

09/11/2023	Special Investigation Intake 2023A1028081
09/12/2023	Special Investigation Initiated - Letter
09/12/2023	APS Referral APS referral made to Centralized Intake.
09/19/2023	Contact - Face to Face Interviewed Admin/Amanda Raglin at the facility.
09/19/2023	Contact - Face to Face Interviewed Employee A at the facility.
09/19/2023	Contact - Face to Face Interviewed Employee B at the facility.
09/19/2023	Contact - Face to Face Interviewed Employee C at the facility.
09/19/2023	Contact - Face to Face Interviewed Housekeeping staff member 1 at the facility.
09/19/2023	Contact - Document Received Received resident records from Admin/Amanda Raglin.
09/19/2023	Inspection Completed On-site Completed onsite inspection due to this special investigation.

ALLEGATION:

Residents are neglected in memory care and staff do not follow service plans.

INVESTIGATION:

On 9/11/023, the Bureau received the allegations anonymously through the online complaint system.

On 9/12/2023, an Adult Protective Services (APS) referral was made to Centralized Intake.

On 9/19/2023, I interviewed facility administrator, Angela Raglin, at the facility who reported no knowledge of any residents being left in wet briefs or soiled clothing. Ms. Raglin reported all staff are to date and initial brief changes to ensure residents are not sitting in soiled briefs or clothing. There are some residents that will refuse assistance in the memory care unit, but staff will use reapproach techniques to ensure soiled briefs and/or clothing is changed. Ms. Raglin reported Resident A will refuse clothing changes and assistance with toileting intermittently. Resident A has disorientation and confusion and urinates on the floor in the bathroom often. Housekeeping staff members and care staff members routinely clean Resident A's bathroom because of this. Ms. Raglin reported staff have not made any complaints to her about residents not being changed appropriately or in a timely manner. Ms. Raglin reported it would be addressed immediately if brought to her attention, as that behavior would not be tolerated at the facility. Resident families have made no complaints to Ms. Raglin either about this alleged issue. Ms. Raglin provided me Resident A's service plan for my review.

On 9/19/2023, I interviewed Employee A who reported knowledge of residents in memory care not being changed in a timely manner. Employee A reported it occurs during second and third shifts. Employee A confirmed all staff are to initial and date when changing briefs, but not all staff are compliant or consistent with this practice. Employee A stated this issue was reported to the second and third shift supervisors, but it is still occurring. Employee A also confirmed Resident A urinates daily on the floor due to confusion and the floor is stained in the bathroom from the urine.

On 9/19/2023, I interviewed Employee B at the facility who reported knowledge of staff not always completing residents clothing or brief changes in a timely manner. Employee B also confirmed staff are to date and initial brief changes in the memory care unit but there are still issues with second and third staff not completing it in a timely manner and/or not being compliant with this practice. Employee B reported knowledge of the issue being reported to the shift supervisors to address, but the issue is ongoing. Employee B reported Resident A does urinate daily on the floor with housekeeping staff and care staff cleaning it up. Resident A also has a history of refusing care intermittently and requires reapproach techniques.

On 9/19/2023, I interviewed Employee C at the facility whose statements were consistent with Employee A's statements and Employee B's statements.

On 9/19/2023, I reviewed Resident A's service plan which revealed the following:

- Diagnosis of dementia.
- Requires regular prompting due to confusion and disorientation.
- Communicates independently and can follow directions.
- Has limited safety awareness and requires supervision.
- Wanders intrusively, but easily redirected.
- Exhibits resistive/uncooperative behaviors occasionally, but less than daily.
- Does not demonstrate verbal, social, or disruptive behaviors.
- Independent with grooming, oral care, upper and lower body dressing, showering, and toileting.
- Requires reminders to shower.
- Independent with mobility, transfers, repositioning, and does not use a mobility device.
- Facility staff manage all medications, housekeeping, laundry, and meals.

On 9/19/2023, I completed an inspection of the memory care unit and did not smell urine. Residents observed were clean and groomed, including Resident A who was observed walking the hallways of the memory care unit.

I also completed an inspection of Resident A's room and bathroom which revealed the bathroom floor appears to be soiled and is heavily stained from the urine. There was also detection of a very faint smell of urine in the bathroom, despite the bathroom having been cleaned that morning. The linoleum flooring was also separating from the floorboard and floor trim along the wall due to the consistent urination on the floor.

On 9/19/2023, I interviewed housekeeping staff member 1 who confirmed the bathroom was cleaned that morning. Housekeeping staff member 1 reported the floor is stained from the urine and multiple cleaners have been used to remove the staining, but it has not worked. Housekeeping staff member 1 reported facility staff and management are aware of the staining in the bathroom. Housekeeping staff member 1 reported [they] clean the bathroom on Tuesdays and Thursdays and other housekeeping staff clean it on other days of the week. Housekeeping staff member 1 could not confirm if care staff also assist with cleaning of the bathroom floor.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.

ANALYSIS:	It was alleged residents in memory care are left in soiled briefs and clothing. Onsite investigation, interviews, and review of documentation reveal that while there appears to be an issue with residents not being changed in a timely manner between second and third shifts, it could not be confirmed. Residents observed in memory care were clean and groomed and there was no detection of urine smell in the common areas, kitchenette, or hallways in the memory care unit. However, onsite investigation, interviews, and review of documentation revealed Resident A consistently urinates on the floor of the bathroom in [their] room with care staff, management, and housekeeping staff aware of this behavior. The floor is heavily stained from the urination and is need of replacement due to the consistent urination. Resident A's consistent urination on the floor is unsanitary and could result in a fall with potential injury. Also, Resident A's service plan states [they] are independent with toileting and management of bowel and bladder. Resident A's consistent daily urination on the floor conflicts with the level provision of independent in the service plan. Resident A should not be considered independent with toileting and of bowel and bladder if Resident A is urinating daily on the floor. The facility does not have appropriate service plan provisions in place to address this behavior, to keep Resident A's bathroom sanitary and clean, and to keep Resident A safe while toileting. Therefore, the facility is in violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

There only one care staff member on third shift in the memory care unit.

INVESTIGATION:

On 9/19/2023, Ms. Raglin reported there are four care staff in the building during third shift with one care staff member assigned to the memory care unit full time and one float staff member that goes between assisted living and the memory care unit to assist as needed. Two care staff members are assigned to assisted living. There are nine residents total in memory care. Ms. Raglin reported no knowledge of care staff leaving memory care unattended during third shift for any reason. Ms. Raglin said that would not be tolerated, that memory care staff are to remain in the memory

care unit their entire shift and if they require assistance with residents, then they are to call the float care staff member.

On 9/19/2023, Employee A reported knowledge of third shift staff members leaving the memory care unit unattended more than once during the summer months but those employees do not work at the facility any longer. Employee A could not identify which dates the memory care unit was left unattended, just that it recently occurred during the summer months. Employee A reported that while most residents sleep on third shift, there are residents in the memory care unit who are restless and wander at night and it is not safe to have only staff member in memory care. Employee A reported the float staff member should be assigned full time to the memory care unit on third shift to assist with care, wandering, and to ensure safety of the residents and care staff members on duty. Employee A reported this concern has been brought to the attention of management, but only one care staff member continues to be assigned to the memory care unit during third shift.

On 9/19/2023, I interviewed Employee B who also reported knowledge that third shift staff members left the memory care unit unattended during the summer months, but those employees are no longer at the facility. Employee B could not identify which dates the memory care unit was left unattended. Employee B confirmed there is only one care staff member in the memory care unit on third shift with a float staff member that goes between assisted living and the memory care unit during third shift. Employee B also confirmed there are several residents in the memory care unit that wander during the evening and nighttime hours and that require assistance with care routines.

On 9/19/2023, I interviewed Employee C at the facility whose statements were consistent with Employee A's statements and Employee B's statements.

On 9/19/2023, I reviewed the service plans of memory care residents which revealed the following:

- Resident A, Resident B, Resident D, Resident E, Resident F, and Resident G demonstrate wandering.
- Resident A, Resident B, Resident D, Resident E, and Resident G demonstrate altered sleep cycle from 10pm to 6am requiring intervention.
- Resident D, Resident E, Resident F, Resident G, Resident H and Resident L require one person assistance with care routines.
- Resident H and Resident L require one person assistance with transfers and or functional mobility with or without use of a wheelchair and/or assistive device.
- Resident D, Resident E, and Resident G require hourly supervision.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(5) The home shall have adequate and sufficient staff on duty at all times who are awake, fully dressed, and capable of providing for resident needs consistent with the resident service plans.
ANALYSIS:	It was alleged there is only one care staff member on third shift in the memory care unit and that third shift staff have left the memory care unit unattended on third shift as well. Onsite investigation, interviews, and review of documentation confirm there is one staff member allocated for third shift in the memory care unit. Also, staff interviews are consistent with knowledge of the memory care unit being left unattended by care staff during the summer months. However, dates of the allegation could not be determined, and the staff members that allegedly left the memory care unit unattended are no longer at the facility. However, review of memory resident service plans revealed the following: • Six memory care residents demonstrate wandering behaviors, requiring redirection. • Five memory care residents demonstrate altered sleep cycles from 10pm to 6am. • Six memory care residents require one person assistance with care routines. • Two memory care residents require one person assistance with transfers and or functional mobility with or without use of a wheelchair and/or assistive device. • Three residents require hourly supervision. Multiple residents in memory care have significant needs concerning wandering, altered sleep cycles from 10pm to 6am, requiring one person assistance with care routines and with transfers and functional mobility, and require hourly supervision due to behaviors and/or wandering. One care staff person on duty in the memory care unit on third shift is not sufficient to provide appropriate assistance to meet the needs of the residents in a timely manner or to ensure safety of the residents and even the staff on duty during third shift.
CONCLUSION:	**VIOLATION ESTABLISHED**

Additional Findings

INVESTIGATION:

On 9/19/2023, during the onsite investigation, it was discovered Resident C is diagnosed with Alzheimer's disease and requires increased supervision and assist from care staff. Resident C currently resides in assisted living; however, facility care staff take Resident C to the memory care unit during the nighttime hours and allow Resident C to sleep in a recliner in common area of the memory care unit so staff can supervise Resident C appropriately. Review of Resident C's service plan revealed no evidence this is care planned and/or that Resident C and/or [their] authorized representative has agreed to this.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.
ANALYSIS:	Resident C is an assisted living resident, but facility staff take Resident C to the memory care unit and allow Resident C to sleep in a recliner in the common area during the nighttime hours. There is no evidence in the service plan that Resident C and/or [their] authorized representative has agreed to this. Facility staff are not providing Resident C care in accordance with [their] service plan. Violation found.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 9/19/2023, during the onsite investigation, it was discovered that Resident B's medication Seroquel Tab 25mg in which ½ of a tablet (12.5mg) is to be taken by mouth twice a day was administered as a crushed medication. Further investigation of Resident B's medication administration record revealed there is no physician order on file to crush Resident B's medications.

APPLICABLE RULE	
R 325.1932	**Resident Medications**
	(1) Medication shall be given, taken, or applied pursuant to labeling instructions or signed orders by the prescribing licensed health care professional.
ANALYSIS:	Resident B's medication was not administered as prescribed by the physician. The medication was crushed by facility staff and there is no physician order on file to crush Resident B's medications. Violation found.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an approved corrective action plan, I recommend the status of this license remains the unchanged.

Julie Viviano

10/12/2023

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Julie Viviano Date
Licensing Staff

Approved By:

Andrea L. Moore

10/30/2023

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