GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

October 17, 2023

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

RE: License #: AH500236728
Investigation #: 2023A0585091
The Arbor Inn

Dear Mr. 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 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 #:	2023A0585091
Complaint Receipt Date:	09/18/2023
Investigation Initiation Date:	09/19/2023
Report Due Date:	11/18/2023
Licensee Name:	The Warren Arbor Co.
Licensee Address:	14030 E 14 Mile Rd. Warren, MI 48088
Licensee Telephone #:	(586) 296-3260
Administrator:	Francesca 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?
Residents are not getting their showers on time.	No
The facility is understaffed.	No
The facility is messing up the residents' medication.	Yes
Facility is not clean.	No
Additional Findings	No

III. METHODOLOGY

09/18/2023	Special Investigation Intake 2023A0585091
09/19/2023	Special Investigation Initiated - Letter Referral sent to Adult Protective Services (APS).
10/06/2023	Inspection Completed On-site Completed with observation, interview, and record review.

ALLEGATION:

Residents are not getting their showers on time.

INVESTIGATION:

On 9/19/2023, the Department received a complaint through the online complaint system which read the facility is not showering the residents on time. The complainant was not available for additional information or comments.

On 9/19/2023, a referral was made to Adult Protective Services (APS).

On 10/5/2023, the Department received additional allegations through the online complaint system.

On 10/5/2023, an onsite was completed at the facility. I interviewed administrator Fran DePalma at the facility. Ms. DePalma stated that residents are getting their showers. Ms. DePalma shared copies of residents' shower sheets for review.

During the onsite, I interviewed Employee #1 at the facility. Employee #1 stated that residents are getting their showers unless they refuse. She stated that if they refuse, they try a different approach and sometimes it works.

Employee #2 and Employee #3 statements were consistent with Ms. DePalma regarding showers.

During the onsite, I interviewed Resident A who stated that she gets her showers on the day she is scheduled to. She stated that staff is very helpful in caring for her needs.

I interviewed Resident B and Resident C who both stated that there are no issues with their showers.

Shower sheets for Resident A, Resident B, and Resident C were consistent with Ms. DePalma and employees' statements regarding residents' showers.

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:	Based on interviews with Ms. DePalma, employees, and residents, showers were given consistent with their service plans. Therefore, this claim could not be substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The facility is understaffed.

INVESTIGATION:

The complaint received on 10/5/2023 alleged that the facility does not have enough staff.

During the on-site inspection at the facility, I interviewed Ms. DePalma who stated there were currently 60 assisted living and 19 memory care residents in the facility.

Ms. DePalma stated that there is enough staff to care for the needs of the residents. She stated that there are two care staff on each shift in assisted living and two caregivers in memory care. She stated that if a staff call in, they make every effort to find coverage. Ms. DePalma explained that if they can't find coverage then the director of healthcare will work. She stated that medication technician also assists with personal care of the residents when they are not administering medication. Ms. DePalma stated there were three shifts, however some staff worked 12-hour shifts to care for the needs of the residents. Ms. DePalma stated she utilized staffing agency when they need to and is currently working to hire more staff. Ms. DePalma stated on both day and afternoon shifts there were usually two medications technicians and two resident aides assigned to the assisted living unit, then two staff assigned to the memory care unit. Ms. DePalma stated sometimes one staff member assigned to the memory care unit was a medication technician; however, if not, then an assisted living medication technician would administer medications to the memory care resident's medications. Ms. DePalma stated on night shift, there were two staff assigned to the assisted living unit, usually both were medication technicians and one to two staff assigned to the memory care unit. Ms. DePalma stated she assigned two staff to the memory care unit, however if staff called off work, then sometimes the unit would have one staff member. Ms. DePalma stated that staff assigned to the assisted living will also assist memory care staff, as well as relieve the staff member for breaks.

Employee #1 statement was consistent to Ms. DePalma. Employee #1 stated that there is also a medication technician that goes from memory care to assisted living. She stated that usually it is one medication technician in assisted living and one in memory care.

Employee #2 statement were consistent with Ms. DePalma and Employee #1 that there are 79 residents at the facility. Employee #2 stated that she is the only caregiver working on that side of the building, but the medication technician helps when they are not passing medication. Employee #2 stated that Employee #1 also assist with the care because they had a call in. She stated that it is supposed to be two caregivers and a medication technician.

During the on-site, I observed the memory care unit in which two staff were on duty. I observed some residents were ambulatory while others utilized wheelchairs or walkers in which most were gathered for activities in the common area.

I reviewed the resident roster and employee list which both read consistent with statements from Ms. DePalma. I reviewed the facility's staff schedule dated July 2023 through October 2023 in which read consistent with statements from Ms. DePalma.

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 plan.
ANALYSIS:	Review of facility documentation, staff interviews and observations revealed although the memory care unit had one staff member on duty, staff assigned to the assisted living unit would also assist with resident care. Based this information, this allegation was not substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The facility is messing up the residents' medication.

INVESTIGATION:

The complaint alleged that the facility is messing up the residents' medication. The complaint alleged that the book says that the medication is given when it is not. Contact could not be established with the complainant; therefore, additional information could not be obtained.

Ms. DePalma stated that there were some issues where the medication was not given. She stated that staff are being in-serviced on the administering of medication.

Employee #1 stated that when there is a medication error, staff are to report it to the supervisor. Employee #1 stated that she is not aware of any errors and staff are good about reporting errors.

Resident A's service plan read, "resident able to express needs and concerns. Medication passer to administer all medications as ordered by the physician."

Resident A's MAR shows that medication was given as prescribed.

Resident B's service plan read, "resident able to express needs and concerns. Medication passer to administer all medications as ordered by the physician."

A review of Resident B's MAR revealed that she was prescribed Buspirone tab 7.5 mg by mouth every 8 hours for anxiety. The MAR shows that Buspirone was not given to Resident B on September 1 through September 7, and on September 9-14, September 16, and on September 21. Donepezil 10 mg was prescribed to be given as 1 tablet by mouth daily at bedtime. The MAR shows that Donepezil was not given on September 13. Trazodone tab 50 mg was prescribed to be given 1 tablet by mouth daily at bedtime for insomnia. The MAR shows that Trazodone was not given on September 14.

Resident C's service plan read, "Medication passer to administer all medications as ordered by the physician."

A review of Resident C's MAR revealed that resident was prescribed Levothyroxine tab 25 mg take 1 tab by mouth once daily for thyroid. On September 12 resident did not receive Levothyroxine as prescribed. The dose was also missed on September 14 and marked as not available will order.

Resident D's service plan read, "resident able to express needs and concerns. Medication passer to administer all medications as ordered by the physician."

A review of Resident D's MAR revealed that resident was prescribed Cetirizine 10 mg to be given one tablet by mouth daily at bedtime for nighttime congestion. The MAR shows that Cetirizine was not given on September 14. Atorvastatin tab 40 mg to be taken 1 tablet by mouth daily at bedtime for cholesterol. Atorvastatin was not given on September 14. Eliquis tab 5 mg was prescribed as 1 tablet by mouth twice daily. On September 14 Eliquis was only given once to the resident. Melatonin 5 mg prescribed 1 tablet by mouth daily at bedtime for sleep. On September 14, Melatonin was not given. Metformin 500 mg – take 1 tablet by mouth twice daily for blood sugar. On September 14, Metformin was only given once to the resident. Senna Plus 8.6-50 mg – take 1 tablet by mouth twice daily for constipation. On September 14 Senna Plus was only given once.

Resident E's service plan read, "resident able to express needs and concerns. Medication passer to administer all medications as ordered by the physician."

A review of Resident E's MAR revealed that resident was prescribed Lorazepam tab 0.5 mg – take 1 tablet by mouth twice daily. Lorazepam was not given on September 13. Melatonin tab 12 mg – 1 tablet by mouth daily at bedtime. Melatonin was not given September 13. Metoprol tab 25 mg – take ½ tablet by mouth twice daily. Metoprol was only given once September 13. Senna Plus 8.6-50 mg – take 2 tablets by mouth twice daily. Senna Plus was only given once on September 13.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(2) The giving, taking, or applying of prescription medications shall be supervised by the home in accordance with the resident's service plan.
ANALYSIS:	Medication was not always given as prescribed. The MARs for Resident B, Resident C, Resident D and Resident E shows that medication was not always given as prescribed. Therefore, this claim was substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The facility is not clean.

INVESTIGATION:

The complaint read the facility is not clean. I was unable to obtain additional information from the complainant. Ms. DePalma stated housekeeping staff worked 8:00 AM to 2:00 PM and the supervisor worked 7:30 AM to 4:00 PM. While on-site, I observed the assisted living and the memory care unit. There were no odors in the rooms at that time. I observed random residents' rooms. The rooms were clean, and I observed housekeeping staff cleaning throughout the facility.

Ms. DePalma stated that residents' rooms are cleaned every day. She stated that there is a full-time housekeeper and two part time housekeepers. She stated that addition to the housekeepers, there is also a janitor at the facility in the evening time five times a week. Ms. DePalma stated that caregivers also assist with the cleaning at the facility.

Employee #1 and Employee #2 stated that residents' rooms are cleaned every day, and some are cleaned several times a day depending on the need at that time.

I interviewed Employee #3 who stated housekeeping staff do a good job keeping the facility clean. Employee #3 stated staff also worked as team to ensure the facility was clean. Employee #3 stated that they clean dining room and counters every day. She stated that they clean residents' rooms every day.

APPLICABLE RULE	
R 325.1962	**Exteriors.**
	(2) The premises shall be maintained in a safe and sanitary condition and in a manner consistent with the public health and welfare.
ANALYSIS:	During the onsite, residents' rooms, dining rooms, and common areas were inspected. The facility was cleaned and there were no issues. Therefore, this claim could not be substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

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

Brender L. Howard

10/18/2023

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Brender Howard Date
Licensing Staff

Approved By:

Andrea L. Moore

10/17/2023

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