GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

Daniel Fessler
Arden Courts (Sterling Heights)
11095 14 Mile Rd
Sterling Heights, MI 48312

October 11, 2024

RE: License #: AH500293047
Investigation #: 2024A1022074
Arden Courts (Sterling Heights)

Dear Daniel Fessler:

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.

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 #:	AH500293047
Investigation #:	2024A1022074
Complaint Receipt Date:	08/07/2024
Investigation Initiation Date:	08/07/2024
Report Due Date:	10/06/2024
Licensee Name:	Arden Courts of Sterling Heights MI LLC
Licensee Address:	16th Floor 333 N. Summit St. Toledo, OH 43604
Licensee Telephone #:	(419) 252-5500
Administrator:	Grace Dezern
Authorized Representative:	Daniel Fessler
Name of Facility:	Arden Courts (Sterling Heights)
Facility Address:	11095 14 Mile Rd Sterling Heights, MI 48312
Facility Telephone #:	(586) 795-0998
Original Issuance Date:	06/09/2009
License **Status:**	REGULAR
Effective Date:	08/01/2024
Expiration Date:	07/31/2025
Capacity:	56
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
The Resident of Concern (ROC) did not receive appropriate care.	Yes
The ROC did not receive her medications as prescribed.	Yes
Additional Findings	Yes

III. METHODOLOGY

08/07/2024	Special Investigation Intake 2024A1022074
08/07/2024	Contact - Telephone call made Complainant contacted by email.
08/28/2024	Contact - Telephone call made Investigation conducted remotely via videoconference.
09/09/2024	Contact - Document Received Email exchange with Resident services coordinator
09/23/2024	Contact - Document Received Email exchange with Resident services coordinator
10/11/2024	Exit Conference

ALLEGATION:

The Resident of Concern (ROC) did not receive appropriate care.

INVESTIGATION:

On 08/07/2024, the Bureau of Community and Health Systems (BCHS) received a complaint that read, “[Name of the Resident of Concern/ROC] was a patient getting cuts and bruises and unstageable bed sores severe urinary tract infection leading to death of patient. On June 15th [name of the ROC] had the ability to feed herself in 28 days she became wheelchair bound and unable to feed herself.”

On 08/08/2024, I interviewed the complainant by phone. The complainant stated that although the ROC had resided in the facility for only 28 days, she quickly declined due to the practices of the facility. According to the complainant, before moving into

the facility, the ROC was able to bear her own weight and walk, although she was slow. Once she moved into the facility, she was not able to walk the distance from her room to the facility common areas and she was put into a wheelchair. Within the first several days of living in the facility, she stopped walking altogether and only used the wheelchair. Soon, she could no longer bear her own weight. She had sustained several bruises, abrasions, and skin tears as a result transfers into the wheelchair. One of the skin tears was to her right forearm. Right after she sustained this injury, she lost the functionality of the fingers of her right hand and needed to be assisted with eating. On 07/12/2024, in the process of being assessed for home care, the ROC was found to be severely hypotensive, and was sent to a local emergency room and died while hospitalized. In the hospital, the family was told that the ROC had multiple skin impairments including the skin tears and abrasions that they knew about, as well as others that they had no knowledge of. They were informed that the ROC had a severe urinary tract infection and a bedsore that was so severe that it was “unstageable.”

On 08/28/2024, I interviewed the administrator and the resident services coordinator (RSC) remotely, in a videoconference. When asked about the ROC, the administrator stated that she had come from her home, where her husband was her primary caregiver. The administrator went on to describe how the ROC’s husband was very devoted to the ROC and wanted her to maintain her independence to the extent possible, but going so far that, in the administrator’s opinion, pushed her (the ROC) to her beyond her limits.

When asked about the ROC’s ability to stand, bear weight and walk with or without the use of an assistive device, such as a walker, the RSC stated that the ROC walked into the facility on her own, but was taken to her room in the unit in a wheelchair. The RSC described the ROC as having “weakness,” and at times, the RSC suspected pain in her feet as the ROC had diabetic neuropathy that affected her feet. Despite encouragement from the caregivers, the ROC began to resist the caregivers’ effort to walk, although she was able to stand with assistance, bear weight and pivot into a wheelchair. According to the ROC’s progress notes, dated 07/04/2024, “…Upon moving in, resident (the ROC) was utilizing a 2-wheeled walker for mobility. Resident was observed experiencing weakness in her legs. Resident was seen by PCP & NP. Medications were reviewed and adjustments were made. An order for nursing & PT (physical therapy) was written and sent to [name of home care provider #1] …”

When asked about the ROC’s ability use her right hand in order to put food into her mouth, both the administrator and the RSC denied knowledge of this being a problem. However, according to the administrator, the ROC seemed to lose interest in eating and her intake of food began to decline. Her poor oral intake was noticed by caregivers and documented in her individual service notes, starting on 07/06/2024 when a caregiver documented that the “Resident did not eat breakfast. She ate (only) 20% of lunch.” Documentation of the ROC’s poor food intake continued until she until she left the facility for the hospital on 07/12/2024. The

administrator described one occasion when she (the administrator) attempted to feed the ROC, but the ROC clamped her mouth shut and turned her head away.

When asked about the presence of bruising, abrasions, and skin tears, especially the result of transferring in and out of her wheelchair, both the administrator and the RSC denied knowledge that the ROC had sustained bruising or skin tears with transfers or from any other cause. Review of documentation for the ROC revealed an individual service note dated 06/22/2024 that documented "…bruise on right arm. Notify nurse," written by a caregiver and a progress note, written on 07/11/2024 by the RSC, "… Resident also has self-inflicted skin tear on her right forearm that has been steri-stripped until wound heals…" Via an email exchange on 09/09/2024, when the RSC was asked about the 06/22/2024 entry, the RSC replied that she "did not see any further documentation" on the injury. When the RSC was asked how she concluded that on 07/11/2024, the ROC's skin tear was "self-inflicted," she acknowledged that "I (the RSC) am more than certain I wrote the note stating the skin tear was self-inflicted, going off of what staff verbalized to me upon assessing [name of the ROC]'s arm and performing first-aid/wound care."

When asked about pressure wounds, both the administrator and the RSC acknowledged while the ROC had moved into the facility on 06/15/2024 with completely intact skin, by the time she was hospitalized on 07/12/2024, she had pressure wounds on her right heel and on her left buttock. According to the ROC's individual service notes dated 07/05/2024, licensed nurse #1 documented "Was notified by husband of open area on right foot. Cleaned & (illegible) applied. Add to MD (physician) log for follow-up orders." The administrator then stated that sometime after the facility had become aware of the wound of the ROC's right foot, she (the administrator) had been in the room when the ROC was being provided incontinence care and observed a reddened area on her buttock. The administrator did not say what measures were taken to treat this reddened area, but according to the RSC, for any abnormal skin areas, caregivers are instructed that to ensure that those areas be kept clean, dry and covered with a zinc oxide moisture barrier ointment. The RSC stated that when she became aware of a wound on the ROC's buttock, it was more than "redness." According to the progress note dated 07/07/2024, "RSC assisted midnight caregiver with toileting overnight. Resident refused to get up to be assisted in the bathroom… While changing resident, RSC observed an open area the size of a quarter on resident's left buttocks. Also there was a bandage on resident's right heel that appeared to have an open area due to drainage observed on the outside of the bandage… A message will be sent to resident's PCP as well as a f/up (follow up) call Monday morning to [name of home care provider #1] regarding when nursing & PT will begin. If not, the referral will be sent to [name of home care provider #2] to expedite treatment. RSC will notify resident's husband as well to update him."

Review of the ROC's service plan revealed the ROC was at risk for changes in her skin integrity and that caregivers were to observe her skin with bath/shower and report any abnormal areas to nurse. According to the RSC, on shower days,

caregivers were to complete shower sheets and document skin observations. The facility was able to provide only 2 shower sheets for the ROC, the first dated 06/27/2024 and the second dated 07/08/2024. Neither shower sheet indicated any skin impairments, even though on 07/05/2024 the ROC had an opened area on her right foot on 07/07/2024, an opened area on her left buttock. The RSC was not able to offer an explanation for the lack of documentation.

When asked about documentation or acknowledgement that caregivers were using a zinc oxide moisture barrier ointment with each incontinence care when the ROC was found to have compromised skin integrity, via an email exchange on 09/23/2024, the RSC replied, “the caregivers were told by myself (the RSC) and the nurses here to keep her bottom dry & clean & to also apply barrier cream until home care nurse or PCP sees [name of the ROC]. Whichever saw her first to write an official treatment order. It was an implied nursing intervention.”

According to a progress note dated 07/09/2024, “Resident had a visit with [name of home care provider #1] nurse. Nurse suggested hospice referral and wrote wound care orders for resident,” and on 07/11/2024, “…Home care nurse wrote treatment orders for resident’s right heel and left buttock… Home care nurse will be back out within the week to bring supplies.”

The facility provided a Treatment Administration Record (TAR) for the ROC, dated 07/09/2024, with instructions for facility staff members to use to treat the ROC’s wounds. The TAR indicated that the wound on the ROC’s right heel was to have a daily treatment and the wound on her buttock twice daily. However, the TAR was blank, leaving it in doubt whether the ROC had ever received treatment for her wounds before leaving the facility on 07/12/2024. When the RSC was asked about the lack of treatment records, she replied, “On 7/9/24, the home care nurse from [name of home care provider #1] was out and wrote the treatment orders and was bringing in supplies at her next visit. I just transcribed the order onto the MAR/TAR. The home care nurse next visit wasn’t until 9/12/24. Unfortunately, that is when [name of the ROC] was sent out to the hospital.”

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents; adoption; posting and distribution; contents; additional requirements; discharging, harassing, retaliating, or discriminating against patient exercising protected right; exercise of rights by patient's representative; informing patient or resident of policy; designation of person to exercise rights and responsibilities; additional patients' rights; definitions.**
	(2) The policy describing the rights and responsibilities of patients or residents required under subsection (1) shall include, as a minimum, all of the following: **(e) A patient or resident is entitled to receive adequate and appropriate care**
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.**
	(16) "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.

ANALYSIS:	Through interviews and document review, it was established that the facility did not make any attempt to establish the origins of bruising or skin tears, did not note changes in the ROC's skin integrity, and did not obtain appropriate care for the ROC in a timely manner.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The ROC did not receive her medications as prescribed.

INVESTIGATION:

According to the complainant, the ROC had diabetes and required the monitoring of her blood sugars and multiple injections of insulin on a daily basis. The family brought the ROC to the facility on a Friday (06/14/2024) with all of her medications properly labeled with administration instructions, but on the following Monday, they were informed that the ROC had not been administered her insulin. The family member who was the primary caregiver noticed that the ROC was not receiving medications throughout the day as she had when she lived at home. The family member was informed that the ROC had received all of her medications in the morning. The complainant went on to say that there were additional times when the ROC was not administered her medications as prescribed.

Although the complainant alleged that the ROC had moved into the facility on 06/14/2024, the facility's written records documented that her move-in date was not until Saturday, 06/15/2024.

When the facility was asked about the ROC not receiving medications as prescribed, the RSC stated that there had been an occasion when the husband believed that the ROC did not receive her medication, but after the ROC's medication administration record (MAR) was reviewed, it was determined that ROC had received all medications for that day.

According to the medication list submitted by the provider at the time the ROC moved into the facility, her medications included the following:

- Atenolol 25 mg tablet, take 1 tablet daily
- Avapro 150 mg tablet, take 1 tablet daily
- Humalog insulin, 5 units subcutaneous injection three times daily
- Lantus insulin, 20 units subcutaneous injection every evening
- Lasix 40 mg tablet, take 1 tablet twice daily
- Namenda 10 mg tablet, take 1 tablet twice daily
- Seroquel 25 mg tablet, take 1 tablet every evening

- Simvastatin, 40 mg tablet, take 1 tablet daily
- Trilipix 135 mg capsule, take 1 capsule daily

Review of the ROC's MARs for the months of June and July 2024 revealed that for 06/19/2024, the MAR was blank for the Humalog insulin scheduled for both 7:30 am and at 11:30 am. For 06/20/2024, the MAR was blank for the Lantus insulin scheduled for 8 pm. For 06/16/2024, the MAR was blank for the Lasix scheduled for 8am. For both 06/22/2024 and 06/23/2024, the MAR was blank for the Namenda scheduled for 8 pm. According to the MAR, no Trilipix was administered to the ROC and this medication was discontinued on 06/20/2024. When the RSC was asked about these omissions in an email exchange on 09/23/2024, she was only able to address 06/16/2024, when the ROC was out of the facility. The RSC went on to say that "the Triliprix was one of the medications upon moving in. [Name of the ROC's husband] did not want his wife taking and withheld giving us that medication. I (the RSC) contacted our PCP (primary care provider) who later gave a D/C (discontinue) order for it."

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(2) Prescribed medication managed by the home shall be given, taken, or applied pursuant to labeling instructions, orders and by the prescribing licensed health care professional.
ANALYSIS:	Review of medication administration records revealed that ROC did not receive all medications as ordered by the licensed health professional.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

At the time of the interview, the administrator stated that she had been in the room when the ROC was being provided incontinence care and observed a reddened area on her buttock. When asked if this observation had been noted or documented, the administrator replied that it had not.

When the RSC was asked about documentation regarding the progression of the ROC's pressure wounds, made by caregivers when bathing the ROC or providing incontinence care, the RSC was unable to produce any documentation.

APPLICABLE RULE	
MCL 333.20175	**Maintaining record for each patient; wrongfully altering or destroying records; noncompliance; fine; licensing and certification records as public records; confidentiality; disclosure; report or notice of disciplinary action; information provided in report; nature and use of certain records, data, and knowledge.**
	(1) A health facility or agency shall keep and maintain a record for each patient, including a full and complete record of tests and examinations performed, observations made, treatments provided, and in the case of a hospital, the purpose of hospitalization.
ANALYSIS:	The facility did not document important observations made of the ROC's skin integrity.
CONCLUSION:	**VIOLATION ESTABLISHED**

I reviewed the findings of this investigation with the authorized representative (AR) on 10/11/2024. When asked if there were any comments or concerns with the investigation, the AR stated that there were none.

IV. RECOMMENDATION

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

10/11/2024

_____

Barbara Zabitz Date
Licensing Staff

Approved By:

10/08/2024

_____

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