GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 22, 2025

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

RE: License #: AH500293047
Investigation #: 2025A0784054
Arden Courts (Sterling Heights)

Dear Daniel Fessler:

Attached is the Special Investigation Report for the above-mentioned 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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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) 335-5985.

Sincerely,

Aaron L Clum

Aaron Clum, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 230-2778

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

I. IDENTIFYING INFORMATION

License #:	AH500293047
Investigation #:	2025A0784054
Complaint Receipt Date:	06/03/2025
Investigation Initiation Date:	06/04/2025
Report Due Date:	08/02/2025
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:	Taja-Savelle McKnight
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:	08/01/2025
Expiration Date:	07/31/2026
Capacity:	56
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Inadequate supervision for Resident A	Yes
Additional Findings	No

III. METHODOLOGY

06/03/2025	Special Investigation Intake 2025A0784054
06/04/2025	Special Investigation Initiated - On Site
06/04/2025	Inspection Completed On-site
07/22/2025	Exit - Email Report sent

ALLEGATION:

Inadequate supervision for Resident A

INVESTIGATION:

On 6/03/2025, the department received this complaint from adult protective services (APS).

According to the complaint, on 5/28/2025, Resident A had two unwitnessed falls resulting in a scratch mark to her right cheek and was sent to the hospital for evaluation. On 5/29/2025, Resident A returned to the facility and had another unwitnessed fall sustaining a knot above her left eye and bruising around her right eye. There is concern for the supervision of Resident A.

On 6/04/2025, I interviewed administrator Grace Dezern at the facility. Administrator stated Resident A had a fall on 5/26/2025 while walking outside in the enclosed courtyard at the facility. Administrator stated staff had allowed Resident A to walk in the courtyard without direct supervision because it is enclosed and Resident A had demonstrated the ability to do so on her own. Administrator stated that when Residents are in the courtyard, staff continually check on them and that the courtyard is visible through several windows in the hallways of the building which she stated is how staff ended up discovering Resident A had fallen. Administrator stated Resident A moved into the facility on 5/15/2025. Administrator stated Resident A had not had any falls prior to this incident. Administrator stated Resident A can walk with a walker. Administrator stated Resident A is able to sometimes walk

without her walker. Administrator stated that staff observed a bruise to Resident A's left ankle from the fall and that Resident A was reporting pain in her left knee. Administrator stated the fall, and injury was reported to Resident A's physician and authorized representative. Administrator stated staff believed the fall may have been related to Resident A's shoes being too big. Administrator stated that on the evening of 5/28/2025, Resident A was observed by a family member to have a bruise on her forehead. Administrator stated Resident A was taken to the hospital for evaluation per the request of a family member. Administrator stated Resident A returned from the hospital on the morning of 5/29/2025. Administrator stated staff did not know how the bruise was obtained. Administrator stated that on the evening of 5/29/2025, staff assisted Resident to bed and did not notice any new bruising on Resident A. Administrator stated that approximately 30 minutes after putting Resident A to bed, a family member who was visiting reported that they had observed bruising around Resident A's eyes. Administrator stated staff are not certain how the last two injuries to Resident A's face happened. Administrator stated it was possible she had attempted to get out of bed or bend over out of her bed to pick something up and hit her head and face on her side table. Administrator stated Resident A is a bad historian and was unable to recall how she obtained her injuries. Administrator stated Resident A does seem to struggle with her balance more on some days than others. Administrator stated Resident A is supposed to use her walker when she is ambulating but sometimes will walk without it. Administrator stated Resident A was placed on thirty-minute safety checks instead of the normal one-hour checks since 5/29/2025.

On 6/04/2025, I interviewed Resident A at the facility. Resident A appeared well groomed and was pleasant during the interview. Resident A was sitting at a table in the dining area during the interview. Resident A had what appeared to be dark bruising around both of her eyes. When asked about the bruising Resident A reported she did not recall having any bruising and was not in pain. Resident A was unable to recall having any falls. Resident A reported she felt she could walk "just fine" on her own without the assistance of staff. During the interview, Resident A spoke to this writer as if I was someone else, she knew from her past and at times responded to questions with answers that did not appear to meet the context of the questions.

I reviewed facility *INCIDENT REPORTS* for Resident A, provided by administrator. Report dated 5/26/2025, indicated that at 2:39pm Resident A was "observed on the ground in the courtyard by the care team doing their last rounds. Upon assessment of physical condition writer observed bruises to the bilateral clavicles and a small bruise to back of Lt (left) arm and pain to the Lt forearm". Under a section titled *INCIDENT CAUSE*, the report read "Resident shoes are too big". Under a section titled *CORRECTIVE ACTION*, the report read "Assessment of Physical Condition, help resident to her feet, neuro-check initiated. Resident was clean up and dress with clean dry cloths". Report dated 5/26/2025, indicated that at 7:08pm Resident A was "observed walking the courtyard and was observed falling. Care team member assist with the fall. Physical condition was done. Care team noticed bruise to her Lt

ankle and c/o (complaint) for pain in Lt knee". Under the section titled *INIDENT CAUSE*, the report read "Improper Footwear". Under the section titled CORRECTIVE ACTION, the report read "Physical condition was done care team notice a bruise to her Lt ankle, the area was clean and cover with band aide". Report dated 5/28/2025 indicated that at 10:56pm "family member observed a bruise to the middle of her forehead and requested to be sent out to hospital". Under the section titled INCIDENT CAUSE, the report read "Unsure of cause". Under the section titled *CORRECTIVE ACTION*, the report read "Assess resident's physical condition. Called 911 as requested by family member". Report dated 5/29/2025 indicated that at 11:11pm, "Family member reported a bruise to the left eye. Observed bump over the left eye and redness to the eye. Resident does not recall how incident happened". Under a section titled *INCIDENT CAUSE,* the report read "High fall risk". Under the section titled CORRECTIVE ACTION, the report read "ice pack applied. Neuro checks performed. Walker placed in arm length. Instruct resident to call for help when needed".

I reviewed 30 min safety check charting for Resident A, provided by administrator, dated 5/30/2025, 5/31/2025 and 6/01/2025. The charting indicated checks were completed for these dates as described by administrator after Resident A returned from the hospital. No charting was provided beyond 6/01/2025.

I reviewed Resident A's Service Plan, provided by administrator, with an "Effective date" of 4/24/2025. Under a section titled *Walking and Transferring,* the plan indicated Resident A was "independent". Under a section titled *Wandering,* the plan read, in part, "Support: Safety checks 30 minutes first three nights then 1 hour checks thereafter.

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.**
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:	The complaint indicated concern for Resident A's supervision alleging she had two falls on 5/28/2025 and another unwitnessed fall on 5/29/2025 when she sustained bruising around her right eye. The investigation revealed Resident A had two falls, one unwitnessed and one witnessed, on 5/26/2025, and was witnessed on two separate occasions, on 5/28/2025 and 5/29/2025, to have bruises of unknown origin. Interviews with administrator and Resident A, as well as review of incident reporting for Resident A, revealed Resident A has a clear lack of safety awareness and is a high fall risk. Despite this, corrective measures noted on the incident reports and measures noted in Resident A's service plan are inadequate to address her supervision needs in this regard. While administrator reported additional 30 min checks were put in place for Resident A, further review revealed these checks were only put in place for a three-day period and were only in effect for the first three days of Resident A's residency and not in relation to her recent falls. Additionally, review of the service revealed no updates were made to the plan in relation to her falls and necessary corrective measures for her safety. Based on the findings, the facility is not in compliance with these rules.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, it is recommended that the status of the license remain unchanged.

Aaron L Clum 7/08/2025

Aaron Clum Date
Licensing Staff

Approved By:

Andrea L Moore 07/21/2025

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