GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 27, 2026

Melanie Belfry
Arden Courts 11095 East Fourteen Mile Road, LLC
11095 14 Mile Rd
Sterling Heights, Michigan 48312

Arden Courts (Sterling Heights)
License Number: HFA0000096
License Type: Home For The Aged - HFA
Investigation ID: INV0000017

Dear Licensee:

Attached is the report for the Complaint Investigation conducted at the above-mentioned facility. Please review the enclosed report for investigation findings and/or additional required actions, including identification of any necessary corrective actions.

If you have any questions or concerns about the report or the findings, please feel free to contact the Long-Term-Care State Licensing Section at 1-877-458-2757.

Sincerely,
Long-Term-Care State Licensing Section
Health Facility Licensing, Permits, and Support Division
Bureau of Community and Health Systems
LARA-BCHS-LTCSLS@michigan.gov

enclosure

BUREAU OF COMMUNITY AND HEALTH SYSTEMS
COMPLAINT INVESTIGATION REPORT

Facility Name: Arden Courts (Sterling Heights)
License #: HFA0000096
License Type: Home For The Aged - HFA
Investigation #: INV0000017
Survey Date: July 28, 2026

ALLEGATION:

Resident A lacked care consistent with his service plan.

INVESTIGATION:

On July 21, 2026, the Department received allegations which read on June 4, 2026, Resident A experienced an unwitnessed fall between approximately 3:00 a.m. and 6:00 a.m. Staff found the resident moaning in pain. The facility's fall protocol was not initiated. Staff physically moved Resident A to the toilet, after which he vomited. The nurse assessed and suspected a bowel obstruction. The emergency room staff confirmed Resident A had an impacted hip fracture consistent with a fall. This finding conflicted with the facility's initial explanation.

Following the resident's return from hip surgery, the facility did not conduct a care conference, nor were updates made to the resident's safety plan.

On July 12, 2026, the resident's family discovered him unsupervised in the courtyard without his walker. Employee #1 stated, "He always forgets his walker." Lack of supervision was caused by significant understaffing. On July 13, 2026, at approximately 10:47 p.m., the resident sustained another fall, resulting in a head injury. He was subsequently hospitalized and diagnosed with a traumatic brain injury, after which he was admitted to hospice care.

On July 26, 2026, the Department received additional information from the complainant that was consistent with the allegations previously submitted. The complainant reported that staff stated they found the resident in bed, doubled over in pain on June 4, 2026. It was further reported that, despite Resident A's advanced dementia/Alzheimer's disease and clear signs of severe pain of unknown origin, staff did not initiate fall protocols. Instead, staff physically moved Resident A from the bed to the toilet, causing significant distress and vomiting. The resident was subsequently transferred to the emergency department, where he underwent unnecessary physical handling and abdominal testing based on inaccurate information provided by the facility. Diagnostic imaging in the emergency department revealed an impacted hip fracture attributable to a fall. The attending emergency room physician confirmed that the alignment of the injury was inconsistent with the facility's account. The Administrator stated they "had no idea what happened."

The complainant further reported that following Resident A's return to the facility after major hip surgery and rehabilitation at Medilodge, the administration did not conduct a care coordination meeting, care conference, or multidisciplinary review with the family. No enhanced safety measures, updated risk assessments, or increased supervision protocols were implemented or communicated in response to his elevated fall risk.

Additionally, upon Resident A's return, he had explicit orders for physical therapy, occupational therapy, and mobility assistance. Despite these orders, the resident was observed by family members on July 12, 2026, in the courtyard, unsupervised and without his required walker.

On July 13, 2026, at approximately 10:47 PM—less than 36 hours after the family raised concerns regarding lack of mobility enforcement and the absence of a care plan meeting—Resident A experienced a second fall, striking his head and requiring emergency hospitalization.

On July 28, 2026, an on-site inspection was conducted, and staff were interviewed. I interviewed Administrator Melanie Belfry and Employee #1. The administrator reported that Resident A moved out of the home on July 22, 2026, following his second fall on July 13, 2026, and subsequent hospitalization.

The administrator clarified that the first incident occurred on June 6, 2026, when Resident A was found in bed moaning and holding his stomach. There were no indications he had fallen. Staff assisted him to the bathroom twice, and he ambulated without difficulty. Both the administrator and Employee #1 stated Resident A typically walked independently with a steady gait. The administrator also noted that emergency medical services (EMS) were able to stand Resident A to transfer him onto the gurney. She stated there were no signs of a fall, bruising, or difficulty walking.

The administrator explained that on June 10, 2026, at 4:34 PM, prior to Resident A returning from rehabilitation, she met with Employee #1 and Relative A1 to discuss therapy needs and following physician orders documented in his progress notes.

The administrator stated that the only change upon Resident A's return from rehabilitation was that he required a walker for ambulation. Employee #1 recalled an instance when Resident A was walking with Relative A1 and forgot his walker, and she retrieved it for him but could not remember the exact date. She added that the home conducted and documented two-hour checks on all residents.

Regarding staffing, the administrator reported that the home currently housed 48 residents, with four away from the facility. The home is divided into four hallways or "houses." Staff worked eight-hour shifts: 7:00 AM to 3:00 PM, 3:00 PM to 11:00 PM, and 11:00 PM to 7:00 AM. She stated there were 5–6 caregivers or medication technicians on both the day and afternoon shifts, along with a nurse. For the night shift, there were four caregivers and a nurse. Employee #1 stated only one resident required two-person assistance; most were ambulatory and required one-person assistance. Both she and the administrator reported that they assisted on the floor when staffing shortages occurred.

The administrator and Employee #1 clarified that the second incident occurred on July 13, 2026 (Resident A was sent out of the home on June 6, 2026, and did not return until July 3, 2026). The administrator stated she was working the floor that night and observed Resident A ambulating with his walker around 8:30 PM. A spot check was completed at 10:22 PM, and at approximately 10:45 PM, prior to shift change when Resident A was found lying in a puddle of urine and was sent to the hospital. She noted Resident A had a history of urinating in various areas of his room.

On August 11, 2026, email correspondence with the complainant read Resident A passed away on July 27, 2026.

Resident A's face sheet indicated he moved into the home on March 16, 2026, and listed Relative A1 as his emergency contact and responsible party. His Health and Service Evaluation

Results and Service Plan dated April 2, 2026, and signed by Relative A1 on April 7, 2026, were consistent with staff interviews: Resident A communicated his needs, ambulated independently, did not require assistance with escorting, did not require assistance with transferring, required reminders or setup assistance for bathing and grooming, did not require assistance with dressing or toileting, had a history of wandering and poor judgment requiring redirection, had severe memory impairment, and had no falls within the previous 90 days. The May 5, 2026, service plan update remained consistent and noted that he was to receive scheduled spot checks every two hours.

Resident A's admission agreement signed and dated by Relative A1 on March 21, 2026, read in part that a "service plan" means a written statement prepared by the staff in cooperation with the resident or their authorized representative that identifies specific care and maintenance, services, resident activity appropriate for his physical, social, and behavioral needs and well-being and the methods of providing the care and services.

An incident report dated June 6, 2026, at 1:15 PM documented that Resident A was awake in bed, confused, and complaining of abdominal pain. He screamed in pain intermittently and could not describe the source. He was unable to verbalize his last bowel movement, and toileted during the day shift. He also experienced emesis after attempting to eat or drink. Staff contacted Relative A1 and EMS. The report included a statement from Employee #2, who worked on June 5 from 3:00 PM to 11:00 PM and again from 11:00 PM to 7:00 AM. She observed Resident A ambulating at baseline with a steady gait June 5 and later sleeping during rounds on June 6. After 7:00 AM on June 6, staff alerted her when Resident A was found screaming and holding his stomach. Employee #2 stated she and another staff member assisted him in walking, and two additional staff members continued his care. Resident A's physician was notified the same day.

An incident report dated July 13, 2026, at 10:45 PM documented Resident A was found lying supine on the floor in his room during rounds. The floor was covered in urine, and he had hematomas on his forehead and the back of his head. Staff contacted Relative A1 and left a message, notified the supervisor, and contacted Resident A's physician. Resident A was sent to the hospital for evaluation.

A review of Resident A's progress notes dated June 6, 2026, June 10, 2026, and July 14, 2026 (related to the July 13 incident) was consistent with staff statements.

A review of Resident A's June and July 2026 monthly task logs showed staff documented two-hour checks from June 1 through part of June 6. Resident A was then out of the facility from June 6 until part of the day on July 3, 2026. Documentation reflected regular two-hour checks from July 3 through July 13, 2026, when Resident A again left the facility.

A review of the home's June 2026 staffing schedule was consistent with staff statements.

The home's change of condition policy, dated May 2025, aligned with staff actions described in the incident reports. The policy read the service plan may be revised depending on the change in condition following a re-evaluation of service requirements.

Resident A's discharge instructions from Medilodge of Sterling Heights indicate that he was discharged from the rehabilitation center on July 3, 2026. The instructions note that he exhibits significant cognitive impairment related to dementia and attempted to leave the facility due to

confusion and impaired reality testing. His ability to communicate is affected by his cognitive impairment; he was able to verbalize his needs at times, though his communication may be inconsistent due to confusion. The instructions read that he requires one-person assistance with dressing, bathing, and toileting, and that he uses a wheelchair as an assistive device. They also indicate that Prime Homecare Agency was assigned to provide home care services.

Review of Resident A's Prime Homecare Services physical therapy (PT) notes dated July 7, 2026, indicated he used a two-wheel walker for support while ambulating and could walk only short distances due to limited endurance and pain in his left hip. Therapy interventions were planned to address mobility deficits, improve transfer safety, and reduce fall risk. The note also indicated his balance was impaired, and his Tinetti balance score classified him as a high fall risk. He was instructed to use his walker at all times. A PT note dated July 9, 2026, read he required caregiver assistance to safely perform toilet transfers. A July 13, 2026, note indicated Resident A remained a high fall risk due to severe cognitive impairments and an inability to make appropriate safety decisions.

APPLICABLE LICENSING REQUIREMENTS

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.

For Reference:

R 325.1922 Admission and retention of residents.

(5) A home shall update each resident's service plan not less than annually or if there is a significant change in the resident's care needs. Changes must be communicated to the resident and the resident's authorized representative, if any.

ANALYSIS:

A review of the allegations received on July 21, 2026, and July 26, 2026, along with staff interviews, incident reports, staffing records, progress notes, and Resident A's service plan, established that although the facility was initially unaware of the circumstances surrounding Resident A's incident on June 6, 2026, he was subsequently diagnosed with a fractured hip requiring surgical intervention. Staffing documentation did not indicate a lack of supervision during the period in question.

Following Resident A's return from rehabilitation and surgery on July 3, 2026, the facility did not revise or update his service plan to reflect his changed mobility status, including his need for a walker, as confirmed through staff interviews and Prime

Homecare therapy notes. Although the exact cause of the hip fracture could not be determined, the change in Resident A's condition demonstrated an increased fall risk. Rehabilitation discharge instructions further documented that he required one-person assistance with activities of daily living, including bathing, dressing, and toileting. Therapy notes additionally indicated he remained a high fall risk and required caregiver assistance for toileting.

Based on the evidence reviewed, a violation was substantiated for the facility's failure to update Resident A's service plan following a documented change in his mobility needs, activities of daily living assistance requirements, and fall risk.

CONCLUSION: **Violation Established**

ALLEGATION:

The home did not provide Resident A's records.

INVESTIGATION:

On July 21, 2026, the Department received allegations read that the administrator declined to provide room check logs for the fall that occurred on June 4, 2026, as well as incident logs for falls.

When a meeting was requested regarding the June 4, 2026, incident, the Executive Director stated they "had no idea what happened" and declined to provide investigation logs, room check records, or other supporting documentation to the family.

On July 28, 2026, an on-site inspection was conducted, and staff members were interviewed.

The administrator reported that the facility requires a written request form to obtain records. She stated that all requests must be submitted to the record request department for review by the facility's legal team. She further indicated that certain internal documents are not subject to release.

Review of email correspondence dated June 8, 2026, from Relative A1 to the administrator and Employee #1 indicated that Relative A1 provided an update on Resident A's diagnosis and treatment plan, then requested a documented timeline of events from staff, including Resident A's location at the time of the incident, staff and witness logs, daily activity baseline, shift observations, and applicable incident protocols.

Review of Resident A's progress notes dated June 10, 2026, indicated that the administrator met with Relative A1 while Resident A was hospitalized following left hip surgery. The administrator reported to Relative A1 that staff had not been aware of any fall involving Resident

A. The notes further read that Resident A was expected to transfer to rehabilitation for three to four weeks before returning to the community.

APPLICABLE LICENSING REQUIREMENTS

333.20201 **Policy describing rights and responsibilities of patients or residents; adoption; posting; 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:

(b) An individual who is or has been a patient or resident is entitled to inspect, or receive for a reasonable fee, a copy of his or her medical record upon request in accordance with the medical records access act, 2004 PA 47, MCL 333.26261 to 333.26271. Except as otherwise permitted or required under the health insurance portability and accountability act of 1996, Public Law 104-191, or regulations promulgated under that act, 45 CFR parts 160 and 164, a third party shall not be given a copy of the patient's or resident's medical record without prior authorization of the patient or resident.

ANALYSIS: The facility has a written procedure for requesting records. Because some requests were made verbally during a meeting, it could not be determined what specific documentation was requested. Although the allegation could not be substantiated due to insufficient evidence, residents and their authorized representatives have the right to access their records and be informed of the process for obtaining them.

CONCLUSION: **Violation Not Established**

The facility was found to be in substantial noncompliance with the laws or rules evaluated in the investigation. For the substantiated violations, a corrective action plan must be submitted via the Michigan State Licensing System (MI-SLS) by September 14, 2026. The corrective action plan must contain all of the following components:

(a) The actions that will be taken to correct the violation and achieve compliance.

(b) The staff responsible for implementing the actions.

(c) The timeline for the implementation and completion of the actions.

(d) The actions that will be taken to ensure continued compliance with the law or rules.

Jessica Rogers 08/24/2026
Long-Term-Care State Licensing Section

Approved By:
Andrea L. Moore 08/27/2026
Long-Term-Care Manager