GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 11, 2021

Dionissia Sinning
The Arbor Inn
14030 E Fourteen Mile Rd.
Warren, MI 48088

RE: License #: AH500236728
Investigation #: 2021A0784011
The Arbor Inn

Dear Ms. Sinning:

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 (810) 787-7031.

Sincerely,

Aaron L Clum

Aaron Clum, Licensing Staff
Bureau of Community and Health Systems
4809 Clio Road
Flint, MI 48504
(517) 230-2778

enclosure

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

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AH500236728 |
| | |
| **Investigation #:** | 2021A0784011 |
| | |
| **Complaint Receipt Date:** | 01/11/2021 |
| | |
| **Investigation Initiation Date:** | 01/11/2021 |
| | |
| **Report Due Date:** | 03/12/2021 |
| | |
| **Licensee Name:** | The Warren Arbor Co. |
| | |
| **Licensee Address:** | 14030 E 14 Mile Rd.<br>Warren, MI 48088 |
| | |
| **Licensee Telephone #:** | (586) 296-3260 |
| | |
| **Administrator/Authorized Representative:** | Dionissia Sinning |
| | |
| **Name of Facility:** | The Arbor Inn |
| | |
| **Facility Address:** | 14030 E Fourteen Mile Rd.<br>Warren, MI 48088 |
| | |
| **Facility Telephone #:** | (586) 296-3260 |
| | |
| **Original Issuance Date:** | 06/01/1999 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 01/28/2020 |
| | |
| **Expiration Date:** | 01/27/2021 |
| | |
| **Capacity:** | 138 |
| | |
| **Program Type:** | AGED |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Resident A was discharged without proper notification | Yes |
| Additional Findings | No |

## III. METHODOLOGY

| | |
|---|---|
| 01/11/2021 | Special Investigation Intake<br>2021A0784011 |
| 01/11/2021 | Special Investigation Initiated - Telephone<br>Interview conducted with administrator Dion Sinning |
| 01/11/2021 | Contact - Document Sent<br>Email sent to Ms. Sinning with request for investigatory documentation |
| 01/13/2021 | Contact - Document Received<br>Investigative documents received by email from Ms. Sinning |
| 02/11/2021 | Contact – Telephone<br>Contact with Complainant |
| 02/11/2021 | Exit Conference – Telephone<br>Conducted with Ms. Sinning |

**ALLEGATION:**

**Resident A was discharged without proper notification**

**INVESTIGATION:**

On 1/11/21, the department received this online complaint.

According to the complaint, Resident A is a person with Dementia and Alzheimer's who resided at the facility from October 2019 until 11/30/20. Resident A exited the building three times while living at the facility. After the third time, on 11/28/20, Resident A was discharged. Resident A needed to be, and was, moved to a more secure facility. The facility only provided a 48-hour discharge notice for Resident A and required Resident A's authorized representative (Resident

AR) to obtain transportation for Resident A to her new facility. Resident AR paid for a car service to transfer Resident A. The facility did recommend a more appropriate placement for Resident A which she was moved to.

On 1/11/20, I interviewed administrator Dion Sinning by telephone. Ms. Sinning stated Resident A was discharged on 11/30/20 due to the facilities inability to keep her safe. Ms. Sinning stated Resident A was a very active person who would often wander. Ms. Sinning stated that when Resident A first moved to the facility, prior to March 2019 when COVID restrictions began, she was not an exit seeker and did very well at the facility. Ms. Sinning stated that "as the months went on" Resident A started to wander more and appearing restless. Ms. Sinning stated that over the last few months Resident A began exit seeking having been able to get outside of the facility at least four times over the last year with three of those exits during the last couple weeks she was at the facility. Ms. Sinning stated each of these times staff were aware of the exit and were able to bring her back inside quickly to keep her from eloping. Ms. Sinning stated that the last time Resident A attempted to exit, on 11/28/20, she tried to take another resident with her. Ms. Sinning stated that due to the increased exit seeking Resident A had reached a point which the facility did not feel they could provide adequate supervision to keep her safe. Ms. Sinning stated the brevity of the discharge timeframe was related to the fact that not only did Resident A begin to express exit seeking behaviors and intentions more frequently, it was also concerning that she attempted to have another resident go with her. Ms. Sinning stated that due to the increased risk to Resident A's safety, and the potential risk of safety to other residents, the facility issued a 48-hour discharge, or less than thirty days, to the Resident AR. Ms. Sinning stated Resident A was moved to a "sister facility" which maintains a secured memory care (MC) that she stated is much safer for her. Ms. Sinning stated Resident AR was asked to transfer Resident A to her new facility as the facility does not provide such a service.

I reviewed Resident A's *Admission Contract* provided by Ms. Sinning. Under a section of the contract titled Discharge Criteria, the contract indicates that a resident can be given a 24-hour emergency discharge notice for "substantial risk to the resident due to the inability of the home to meet the resident's needs or due to the inability of the home to assure the safety and well-being of the resident, other residents, visitors, or staff of the home".

I reviewed Resident A's service plan provided by Ms. Sinning. Under a section titled *Elopement Risk*, the plan reads, in part, "Poor short term memory-frequent redirection".

I reviewed four internal facility reports titled *Resident Incident Report*, provided by Ms. Sinning which she stated were documented records of each time Resident A was able to get outside of the building while exit seeking. The reports, dated 9/20/20, 11/14/20, 11/22/20 and 11/28/20, read consistently with statements provided by Ms. Sinning.

I reviewed Resident A's discharge notice provided by Ms. Sinning. The notice is dated 11/30/20 and read, in part, "As per our verbal discussion with you today, this letter is to inform you that unfortunately [Resident A] is not within the scope of care that the Arbor Inn can provide due to her elopement attempts. Therefore, we must give you an emergency 48 hour notice to find appropriate placement for [Resident A]. Please find appropriate placement for [Resident A] by December 3, 2020. If you have any further questions, please feel free to contact us Monday through Friday, 9am to 5pm. Please see the attached Discharge Policy, as well as contact information for the Michigan Department of Human Services if you feel the need to file a complaint".

I reviewed *INTERDISCIPLINARY PROGRESS NOTES*, provided by Ms. Sinning which she stated were staff charting notes relative to Resident A. The notes were dated between 9/20/20 and 11/28/20. The notes read consistently with statements provided by Ms. Sinning as it pertains to Resident A's exit seeking behaviors and dates which she exited the building.

| **APPLICABLE RULE** | |
|---|---|
| **R 325.1922** | **Admission and retention of residents.** |
| | **(16) A home that proposes to discharge a resident for any of the reasons listed in subrule (15) of this rule shall take all of the following steps before discharging the resident:**<br>**(a) The home shall notify the resident, the resident's authorized representative, if any, and the agency responsible for the resident's placement, if any, not less than 24 hours before discharge. The notice shall be verbal and issued in writing. The notice of discharge shall include all of the following information:**<br>**(ii) The alternatives to discharge that have been attempted by the home, if any.**<br>**(iii) The location to which the resident will be discharged.**<br>**(iv) The right of the resident to file a complaint with the department.** |

| | |
|---|---|
| **ANALYSIS:** | The complaint alleged the facility discharged Resident A without following proper notification. The investigation revealed that while Resident A reason for discharge was appropriate, the facility did not provide adequate written notice to Resident AR. Review of the discharge notice revealed no specific information regarding alternatives to discharge or the location to which Resident A would be discharged. Additionally, while the notice did indicate a complaint could be filed regarding the discharge, the contact information provided in the notice referenced the wrong department. Based on the findings the allegation is substantiated. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

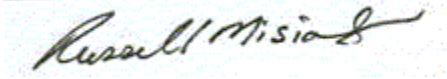
## IV. RECOMMENDATION

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

2/3/21

Aaron Clum — Date
Licensing Staff

Approved By:



2/3/21

Russell B. Misiak — Date
Area Manager