GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 26, 2022

Sara Dickendesher
Senior Living Arbor Grove, LLC
7927 Nemco Way, Ste 200
Brighton, MI 48116

RE: License #:	AH290406205
Investigation #:	2022A1021020
	Arbor Grove Assisted Living & Memory Care

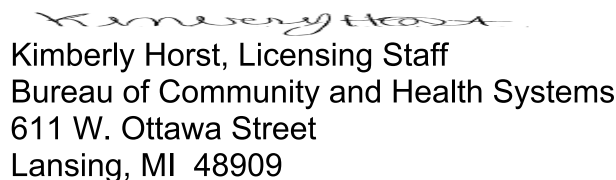
Dear Ms. Dickendesher:

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.

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,



Kimberly Horst, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH290406205
Investigation #:	2022A1021020
Complaint Receipt Date:	01/04/2022
Investigation Initiation Date:	01/04/2022
Report Due Date:	03/03/2022
Licensee Name:	Senior Living Arbor Grove, LLC
Licensee Address:	7927 Nemco Way, Ste 200 Brighton, MI 48116
Licensee Telephone #:	(989) 463-3074
Administrator:	Amanda Warner
Authorized Representative:	Sara Dickendesher
Name of Facility:	Arbor Grove Assisted Living & Memory Care
Facility Address:	1320 Pine Avenue Alma, MI 48801
Facility Telephone #:	(989) 463-3074
Original Issuance Date:	06/02/2021
License Status:	TEMPORARY
Effective Date:	06/02/2021
Expiration Date:	12/01/2021
Capacity:	62
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Facility has insufficient staff.	Yes
Additional Findings	No

III. METHODOLOGY

01/04/2022	Special Investigation Intake 2022A1021020
01/04/2022	Special Investigation Initiated - Letter referral sent to APS
01/05/2022	Inspection Completed On-site
01/26/2022	Exit Conference

ALLEGATION:

Facility has insufficient staff.

INVESTIGATION:

On 1/4/22, the licensing department received a complaint with allegations the facility has insufficient staff in the memory care unit. The complainant alleged the memory care unit has nine residents and at times there is only one caregiver in the unit. The complainant alleged the worker is responsible for providing care, administering medications, serving, cleaning up meals, and activities. The complainant alleged no other staff members assist the memory care unit when there is only one caregiver in the unit.

On 1/5/21, I interviewed the administrator Amanda Warner at the facility. Ms. Warner reported the memory care unit has nine residents. Ms. Warner reported the facility has two 12-hour shifts, 6:30am-10:30pm and 10:30pm-6:30am. Ms. Warner reported on first shift there are two caregivers that are scheduled to work in the memory care unit and on second shift there is one caregiver and a floater that floats between the assisted living and memory care unit. Ms. Warner reported if the facility is short staffed on first shift, a caregiver will be assigned to float between memory care and assisted living. Ms. Warner reported the facility has a mandation policy that is reflected on the schedule. Ms. Warner reported for each shift a caregiver could be

mandated to stay over four hours or come in early four hours. Ms. Warner reported with this mandation policy, it assists with gaps in coverage but does leave a four-hour timeframe of no coverage. Ms. Warner reported caregivers use ipods or their personal cell phones to communicate between each other. Ms. Warner reported management will also assist, if needed. Ms. Warner reported there are no set parameters for the floater as to when to assist or how often to assist. Ms. Warner reported the facility has not used any staffing agencies as there are limited staffing agencies in the area and they do not have care staff. Ms. Warner reported the facility is hiring for all shifts. Ms. Warner reported the facility offers incentives, such as bonuses, for caregivers to pick up additional shifts.

On 1/5/21, I interviewed caregiver Robert Swift at the facility. Mr. Swift reported he typically works first shift in memory care. Mr. Swift reported there are usually two caregivers assigned to the unit but at times there is only one. Mr. Swift reported nine residents require assistance with dressing, seven residents require assistance with showers, three residents have behaviors, and one resident is exit seeking. Mr. Swift reported caregivers are responsible for laundry, cleaning, and serving meals. Mr. Swift reported if there is only one caregiver in the unit, the caregiver must reach out for assistance. Mr. Swift reported caregivers do not check on the memory care unit or readily help. Mr. Swift reported if there is only one caregiver in the unit, resident needs are not met as medications can be late, resident cares are late or not done, and the unit is not kept clean.

On 1/5/21, I interviewed caregiver Mary Zavala at the facility. Ms. Zavala reported lack of staff is an issue at the facility. Ms. Zavala reported at times there is only one caregiver in the memory care unit. Ms. Zavala reported there are seven residents that require showers, eight residents that require assistance with toileting, nine residents that require assistance with dressing, two residents that are a fall risk, one resident that tries to elope, and two residents with behaviors. Ms. Zavala reported if the caregiver is in the back of the unit providing a shower, the caregiver is not aware of what is going on with the other residents in the unit. Ms. Zavala reported residents are not safe when there is only one caregiver in the unit. Ms. Zavala reported there are no parameters for the memory care float as to how much and when they are to assist the unit. Ms. Zavala reported care is delayed and missed when there is only one caregiver in the unit.

At the facility I observed the unit. I observed one resident attempt to sit up by herself which required staff assistance. Another resident was wandering throughout the unit which required constant staff re-direction.

I reviewed the staff schedule for 12/13-1/5. The schedule revealed there was only one caregiver in the memory care unit on first shift for 12/13, 12/17, and 12/23-12/25. In addition, on second shift there were staff shortages on 12/16, 12/18, 12/21-12/22, 12/25-12/26,12/30-12/31, and 1/3-1/4.

I reviewed service plans for the residents in the memory care unit. The service plans revealed there was one resident that required assistance with ambulation, two residents that required assistance with transfers, four residents that are uncooperative with care, one resident with behaviors, nine residents that required assistance with dressing, eight residents that required assistance with showers, four residents that required assistance with toileting, three residents that are incontinent, and two residents that wanders.

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**
For Reference: R 325.1901	**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:	Interviews with the administrator and care staff revealed the facility is to have two caregivers in the memory care unit. However, review of the working staff schedules revealed a pattern of staff shortages in the memory care unit. When there is a staff shortage, there is an assigned “floater” to assist the memory care unit. However, interviews with staff members revealed there are no set parameters for this “floater” as to how much and when they are to assist the unit. By doing so, this cognitively impaired resident population is subjected to potential harm due to the lack of available staff.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend no change in the status of the license.

1/7/22

Kimberly Horst Date
Licensing Staff

Approved By:

01/21/2022

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