GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 8, 2022

Lou Petroni
The Arbor Inn
14030 E Fourteen Mile Rd.
Warren, MI 48088

RE: License #: AH500236728
Investigation #: 2022A1019048

Dear Mr. Petroni:

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. Failure to submit an acceptable corrective action plan will result in disciplinary action. 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. 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,

Elizabeth Gregory-Weil, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 347-5503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH500236728
Investigation #:	2022A1019048
Complaint Receipt Date:	05/02/2022
Investigation Initiation Date:	05/04/2022
Report Due Date:	07/01/2022
Licensee Name:	The Warren Arbor Co.
Licensee Address:	14030 E 14 Mile Rd. Warren, MI 48088
Licensee Telephone #:	(586) 296-3260
Administrator:	Francesca DePalma
Authorized Representative:	Lou Petroni
Name of Facility:	The Arbor Inn
Facility Address:	14030 E Fourteen Mile Rd. Warren, MI 48088
Facility Telephone #:	(586) 296-3260
Original Issuance Date:	06/01/1999
License Status:	REGULAR
Effective Date:	01/28/2022
Expiration Date:	01/27/2023
Capacity:	138
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Inappropriate treatment of Resident A by Employee A.	Yes
Additional Findings	No

III. METHODOLOGY

05/02/2022	Special Investigation Intake 2022A1019048
05/04/2022	Special Investigation Initiated - Letter Notified APS of the allegations via email referral template.
05/04/2022	APS Referral
05/31/2022	Inspection Completed On-site
05/31/2022	Inspection Completed-BCAL Sub. Compliance
06/08/2022	Exit Conference

ALLEGATION:

Inappropriate treatment of Resident A by Employee A

INVESTIGATION:

On 5/2/22, the department received a complaint alleging that Resident A was mistreated by Employee A. The complaint read that on 4/16/22, there was an altercation that took place between the resident and employee in which facility staff reported that the resident became combative with the staff. The complainant alleged that later that day, Resident A complaint of her side hurting and that it appeared to be swollen. The complainant reportedly assumed it was from the alleged altercation. While at the facility, the complainant alleged that she witnessed Employee A interrogate Resident A about the encounter in a confrontational manner. The complainant stated that Employee A came up to Resident A, asked her if she remembered what happened the previous night and proceeded to tell the resident that she physically attacked the employee. The complainant reported that questioning an elderly person with dementia in the manner that Employee A did was unprofessional. The complaint went on to read that on 4/21/22, Resident A informed

her that Employee A had in fact "punched" her during the altercation. The complainant contacted the police after being told about the physical assault.

On 5/31/22, I conducted an onsite inspection. I interviewed administrator Francesca DePalma at the facility. Ms. DePalma stated that Resident A resides in the memory care unit and suffers from dementia. Ms. DePalma acknowledged that she was informed of a situation involved Resident A and Employee A that occurred on 4/16/22. Ms. DePalma stated that there were accusations that Employee A hit or punched the resident and also that she spoke inappropriately to her. Ms. DePalma stated that police were contacted by Resident A's family but she is unaware of the disposition of the case. Ms. DePalma stated that following the incident, she instructed Employee A to stay out of the memory care unit until an internal investigation could be completed. Ms. DePalma stated that Employee A was discovered in memory care after she told her not to be in there and was ultimately terminated as a result of the encounter. Ms. DePalma stated "We know something happened and that she [Employee A] didn't act how she was trained to act. She should've handled the situation better and she didn't follow my direct orders to staff out of memory care until this was sorted out."

Due to cognitive limitations, Ms. DePalma indicated that Resident A would not be able to accurately recall the events, therefore I did not conduct an interview with the resident.

Prior to my onsite, the facility had submitted an incident report to licensing staff Brender Howard pertaining to the allegations. The incident report authored by Employee B read:

> *R/A [Employee A] was sitting in TV area when she notice [sic] resident [Resident A] had been walking back and forth with her coat. R/A asked resident if she was ok resident began calling R/A foul language and stated she'll beat her R/A continued trying to calm resident down when resident walked over and hit R/A.*

The incident report went on to read that there were no injuries to the resident or staff member and that Employee B was able to calm the resident down and redirect her back to bed.

Ms. DePalma stated that Employee C interviewed Employees A and B along with Resident A and handwrote those interview transcripts, which were provided to me while I was onsite. Per the handwritten documentation, Employee A denied hitting the resident and stated "She never hit me she swung on me so I grabbed her hand". Employee C documented that Employee B denied witnessing the altercation but stated that Resident A told her that she was hit by Employee A. Employee C documented that Employee B had concerns about how Employee A was speaking to the resident in an antagonizing manner. Employee C also documented that Employee B was told by Employee A that the resident hit her, despite Employee A stating that she was not hit when directly questioned by Employee C.

Ms. DePalma reported that she did not find out about the allegations until 4/21/22 when rumors were going around the facility that Resident A was hit by Employee A. Ms. DePalma stated that she met with Employee A on 4/21/22 and documented the meeting. The handwritten note authored by Ms. DePalma read:

> *Had meeting with [Employee A]. Discussed walking away from resident is she is unable to, redirect them and call shift supervisor to attend [sic] to resident. Told [Employee A] she needs to attend mandatory dementia training on April 28, 2022 at 3pm or she is volunteering to quit. Will not be working in memory care at the moment.*

Ms. DePalma stated that later that same evening she was contacted by Employee D informing her that Employee A was in memory care and that the police were at the facility to investigate. Ms. DePalma stated that she went up to the facility and spoke with the police and Relative A and also sent Employee A home for the night. Ms. DePalma stated that Relative A informed her that Employee A approached her and Resident A and was questioning her about the incident. Ms. DePalma stated that she terminated Employee A the following day.

Employee A's termination form dated 4/22/22 signed by Ms. DePalma read "Did not follow orders from several hours ago having a meeting regarding resident incident. Was told she would not be in memory care and she approached resident during her shift. She was not assigned in memory care."

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents;**
	(1) A health facility or agency that provides services directly to patients or residents and is licensed under this article shall adopt a policy describing the rights and responsibilities of patients or residents admitted to the health facility or agency. Except for a licensed health maintenance organization, which shall comply with chapter 35 of the insurance code of 1956, 1956 PA 218, MCL 500.3501 to 500.3580, the policy shall be posted at a public place in the health facility or agency and shall be provided to each member of the health facility or agency staff. Patients or residents shall be treated in accordance with the policy.

ANALYSIS:	Employee A's conduct was not consistent with the provision of care expected within this statute.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 6/8/22, I shared the findings of this report with administrator Francesca DePalma at the request of the authorized representative Lou Petroni.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

06/07/2022

Elizabeth Gregory-Weil Date
Licensing Staff

Approved By:

06/07/2022

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