GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 2nd, 2023

Alison Freed
Senior Living Arbor Grove, LLC
7927 Nemco Way, Ste 200
Brighton, MI 48116

RE: License #: AH290406205
Investigation #: 2023A1021041
Arbor Grove Assisted Living & Memory Care

Dear Ms. Freed:

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 #:	2023A1021041
Complaint Receipt Date:	03/01/2023
Investigation Initiation Date:	03/02/2023
Report Due Date:	05/01/2023
Licensee Name:	Senior Living Arbor Grove, LLC
Licensee Address:	7927 Nemco Way, Ste 200 Brighton, MI 48116
Licensee Telephone #:	(989) 463-3074
Administrator:	Amanda Raglin
Authorized Representative:	Allison Freed
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:	REGULAR
Effective Date:	12/02/2022
Expiration Date:	12/01/2023
Capacity:	62
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Facility failed to protect memory care residents.	No
Memory care unit has insufficient staff.	Yes
Additional Findings	No

III. METHODOLOGY

03/01/2023	Special Investigation Intake 2023A1021041
03/02/2023	Special Investigation Initiated - Letter referral sent to APS
03/07/2023	Inspection Completed On-site
05/01/2023	Contact-Document Received Received additional information
05/02/2023	Exit Conference

ALLEGATION:

Facility failed to protect memory care residents.

INVESTIGATION:

On 03/01/2023, the licensing department received an anonymous complaint regarding the protection of the residents. The complainant alleged there are two residents that wander in the memory care unit, enter the enclosed courtyard, and then enter the assisted living unit. The complainant alleged in February 2023, a resident walked the courtyard in the rain wearing open toed shoes and entered back through the assisted living unit.

On 03/02/2023, the allegations in this report were sent to centralized intake at Adult Protective Services (APS).

On 03/07/2023, I interviewed administrator Amanda Raglin at the facility. Ms. Raglin reported within the secure memory care unit there is an enclosed courtyard that can be accessed by two doors. Ms. Raglin reported the courtyard is always accessible to the residents. Ms. Raglin reported when the courtyard door is opened, an alarm goes to the caregivers Ipod to alert them the door has been opened. Ms. Raglin

reported the alarm must be re-set at the door. Ms. Raglin reported when this occurs, the caregiver must visually count the residents to see if they are within the unit, in the courtyard, or have accessed the assisted living unit. Ms. Raglin reported if a memory care resident goes into the courtyard, they can access the assisted living unit. Ms. Raglin reported when the assisted living door is breached, an alert is activated to all caregivers ipods. Ms. Raglin reported the alarm does not need to be re-set at the door. Ms. Raglin reported if this occurs, a staff member will bring the resident back to the memory care unit. Ms. Raglin reported while a resident has accessed the assisted living unit, it is not a common occurrence.

On 05/02/2023, I interviewed authorized representative Allison Freed by telephone. Ms. Freed reported the licensee is in the process of securing the courtyard by sectioning off the courtyard. Ms. Freed reported there will be a designated secure area for memory care residents. Ms. Freed reported the doors to the courtyard will be locked.

While on-site I observed the memory care unit and the enclosed courtyard. One door for the courtyard is located at the front of the unit. Another door is located near the back of the unit closer to the residents' rooms.

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:	While a memory care resident has accessed the assisted living unit through the conjoined courtyard it is not a common occurrence. Interviews conducted revealed the licensee is in the

	process of securing the courtyard by locking the doors and having a designated space for memory care residents.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Facility has insufficient staff.

INVESTIGATION:

The complainant alleged there is insufficient staff in the memory care unit because at times there is only one staff person that works in the unit on first and second shifts.

Ms. Raglin reported the memory care unit is typically staffed with one medication technician and one caregiver. Ms. Raglin reported there are gaps during the day where there is only one staff member in the unit. Ms. Raglin reported the wellness director is located near the memory care unit and can assist, if needed. Ms. Raglin reported employees use the facility iPod system to communicate between each other. Ms. Raglin reported care staff are responsible for caregiving, laundry, light housekeeping, and assisting with meals. Ms. Raglin reported the facility does have a mandation policy in which on each shift there are two caregivers that are scheduled for a possible mandation. Ms. Raglin reported currently there are eight residents in the memory care unit and another resident to move in within the next week. Ms. Raglin reported there is one resident that is a two person assist, two residents that wander, one resident that is combative, and three residents that are a frequent check and change.

On 03/07/2023, I interviewed staff person 1 (SP1) at the facility. SP1 reported she typically works in the memory care unit. SP1 reported there are times during first and second shift there is only one employee in the unit. SP1 reported caregivers can request assistance from assisted living but it can take some time for a caregiver to come or sometimes no one comes. SP1 reported it can be difficult to ensure the safety of the residents if you get stuck in a room with a resident. SP1 reported there is one resident that is a two person assist, two residents that wander, and one resident that is a high fall risk.

On 03/07/2023, I interviewed SP2 at the facility. SP2 reported there are times when there is only one staff member in the unit. SP2 reported he is concerned with the safety of the residents when there is only one staff member in the unit. SP2 reported there is one resident that is a two person assist, one resident with behaviors, and two residents that wander.

I reviewed first and second shift staff schedule for 02/01/2023-02/28/2023. The schedule revealed the following times for first and second shifts which showed at times there is only one caregiver in the unit:

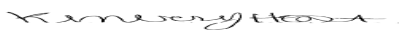
First Shift: 6:00-2:30pm or 7:30-1:30pm
Second Shift: 2:15pm-10:30pm or 4:00pm-9:00pm

I reviewed four service plans for memory care residents. The service plans revealed there was one resident that was a 1-2 person assist, two residents that required bathroom assistance, two residents that required assistance with ambulation, two residents that wanders, and two residents that were resistive to care.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(5) The home shall have adequate and sufficient staff on duty at all times who are awake, fully dressed, and capable of providing for resident needs consistent with the resident service plans.
ANALYSIS:	Review of resident's service plans revealed there is a resident that can require two- person assist transfer. However, at times there is only one staff person scheduled to work in the unit. By scheduling one staff member in the unit, this cognitively impaired resident population is subjected to potential harm due to the lack of available staff.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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



05/02/2023

Kimberly Horst Date
Licensing Staff

Approved By:

05/02/2023

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