GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

June 15, 2023

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

RE: License #: AH500236728
Investigation #: 2023A1027067
The Arbor Inn

Dear Licensee:

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 877-458-2757.

Sincerely,

Jessica Rogers

Jessica Rogers, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 285-7433
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH500236728
Investigation #:	2023A1027067
Complaint Receipt Date:	05/11/2023
Investigation Initiation Date:	05/12/2023
Report Due Date:	07/10/2023
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:	136
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
The facility lacked an organized program for protection, care, and abuse.	Yes
The memory care unit lacked two staff members on duty.	No
The food was cold.	Yes
The facility lacked cleaning.	No
Additional Findings	No

III. METHODOLOGY

05/11/2023	Special Investigation Intake 2023A1027067
05/12/2023	Special Investigation Initiated - Letter Email sent to Ms. DePalma and Mr. Petroni requesting documentation
05/16/2023	Contact - Document Received Additional information and allegations received anonymously
05/18/2023	Contact - Document Received Email received from Ms. DePalma with requested documentation
06/01/2023	Inspection Completed On-site
06/15/2023	Inspection Completed-BCAL Sub. Compliance
08/21/2023	Exit Conference Conducted by voicemail with Mr. Petroni, then by email

ALLEGATION:

The facility lacked an organized program for protection, care, and abuse.

INVESTIGATION:

On 5/11/2023, the Department received a complaint through the online complaint system which read Resident A resided at the facility in the memory care. The complaint read the memory care unit was supposed to be locked, however the facility blocked the memory care door with cabinets to prevent them from leaving. The complaint read staff yell at the residents. The complaint read resident's clothes were not changed. The complaint read residents lacked bathing and care. The complaint read residents lacked changing of their briefs frequently. The complaint read Employee #1 was the only memory care staff who cleaned residents.

On 5/15/2023, the Department received additional information anonymously which read residents had not received showers. The complaint read "*staff members were verbally abusing residents by cursing at them, calling them names, and yelling at them*." The complaint read staff members were falling asleep on the job at night. Due to the anonymous nature of the complaint, I was unable to obtain additional information from the complainant.

On 6/1/2023, I conducted an on-site inspection at the facility. I interviewed administrator Francesca DePalma. Ms. DePalma stated the memory care was locked in which a code was required to enter and exit the memory care unit's doors. Ms. DePalma stated the memory care unit doors were alarmed in which if the doors were opened without the code or held open, an alarm would sound. Ms. DePalma stated a few residents wandered within the memory care unit. Ms. DePalma stated staff charted by exception in which Employee #2 maintained a resident shower schedule for staff. Ms. DePalma stated Employee #1 was suspended then terminated for withholding Resident B's breakfast tray and calling her a name. Ms. DePalma stated it had not been reported to her that staff were sleeping at night. Ms. DePalma stated there were cameras within the memory care unit in which maintained recordings for 30 days, thus she would have investigated allegations of staff sleeping by observing the cameras if needed.

While on-site, I observed the memory care unit. I observed Ms. DePalma and other staff enter and exit the memory care unit using a code. I observed the doors were alarmed after being held open in which a staff member walked to the door to observe the area and entered the code. I observed three staff working and 12 memory care residents, including Resident A. I observed the residents appeared well groomed and dressed in clean clothing. I observed staff assisting residents as well as them interacting positively with the memory care residents. I observed the memory care residents appeared to interact positively with staff. I observed a medication and a treatment cart parked in front of the memory care south exit door near apartment 716. I observed a sign on the door read "Do not open alarm will sound" and the alarm pad was next to the door. Ms. DePalma stated there a was newer resident who wandered, and the medication/treatment carts were not supposed to be parked in that location.

While on-site, I interviewed Employee #4 whose statements were consistent with Ms. DePalma. Employee #4 stated residents were to receive showers weekly.

Employee #4 stated she worked afternoons so she would change resident's clothing after meals if they were dirty or stained. Employee #4 stated most memory care residents were ambulatory or could transfer to a wheelchair in which they could provide some assistance with bathing and grooming.

While on-site, I reviewed Employee #1's file which read consistent with statements from Ms. DePalma. Employee #1's records read in part her date of hire was 11/15/2022. Employee #1's training records read in part she received a copy of The Resident Rights and Responsibilities and the facility's resident abuse policy on 11/22/2022. Employee #1's corrective action form read in part she was suspending on 5/10/2023 and maintained additional documentation which included Resident B's statement and Employee #3's witness statement. Employee #1's termination form dated 5/16/2023 read in part the explanation for termination was resident abuse and neglect.

While on-site, I reviewed the facility's abuse and neglect policy with read consistent with actions taken by Ms. DePalma.

I reviewed Resident A's face sheet which read in part her date of admission was 11/9/2022 and Relative A1 was the first contact to notify for emergencies. The face sheet read in part she had a diagnosis of Alzheimer's Dementia, Anemia (normocytic), history of breast cancer, H. Pylori infection, Folic Deficiency, B12 Deficiency, change in consistency – stool, urinary incontinence, nasal fracture.

I reviewed Resident A's admission contract dated 11/8/2022 and signed by Relative A1 which read she was assigned a private apartment in the Reflections unit. The contract read in part the residents identified with a need for the "Reflections" unit would have a wander guard placed around his/her ankle in which the security system allowed them to move freely around the unit. The contract read in part services provided were assistance with personal care (bathing, grooming, dressing) and personal laundry.

I reviewed Resident A's service plan which read in part she was independent with ambulation and had history of one fall. The plan read in part Resident A was independent with bathing but may require reminders and assistance preparing for the shower. The plan read in part Resident A was independent with dressing, grooming and toileting. The plan read in part Resident A was independent with cognition in which she was alert and orientated to all spaces, as well as able to make healthcare and safety decisions. The plan read in part under elopement that Resident A would walk away in the building. The plan read in part Resident A had left another facility or her home in which required someone to search for her and it was an isolated incident.

I reviewed the memory care shower schedule which read in part Resident A's showers were weekly on Wednesday mornings. The shower schedule read in part refused showers were to be offered on Sundays and to ensure residents had a clean

set of towels on shower days. The schedule read in part all residents were to be assisted with bathing and staff were to notify the nurse if a resident refused scheduled weekly showers as well as showers on Sunday.

I reviewed Resident A's chart which included March 2023 and May 2023 bath sheets and documented her weekly showers. The March 2023 bath sheet read her showers were not completed on 3/1/2023 and 3/29/2023. The March 2023 bath sheet read her showers were completed on 3/8/2023, 3/11/2023, 3/15/2023, and 3/24/2023. The May 2023 bath sheet read Resident A's showers were completed on 5/3/2023, 5/11/2023, and 5/17/2023. The bath sheet read on 5/24/2023 Resident A refused a shower and on 5/29/2023 a shower was completed. The bath sheet read 5/31/2023 was left blank. The bath sheets read in part everyone was to get a shower every week.

I reviewed Resident A's interdisciplinary progress notes which read in part on 3/2/2023, and twice on 3/7/2023, she opened the #4 fire door but did not go out. The notes read in part on 3/12/2023 Resident A was observed outside the #4 fire door in which staff responded to the alarm and she was re-directed back into the facility.

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. Rule 1. As used in these rules:**
	(p) "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.
For Reference: R 325.1933	**Personal care of residents.**
	(2) A home shall afford a resident the opportunity and instructions when necessary for daily bathing, oral and personal hygiene, daily shaving, and hand washing before meals. A home shall ensure that a resident bathes at least weekly and more often if necessary.
For Reference: R 325.1964	**Interiors.**
	(11) A doorway, passageway, corridor, hallway, or stairwell shall be kept free from obstructions at all times.
ANALYSIS:	Review of Resident A's records revealed she had a diagnosis of Alzheimer's Dementia and admitted to the facility's Reflections unit, however review of her service plan revealed she was alert and orientated, as well as able to make healthcare and safety decisions. Resident A's plan read she previously sought exit from her previous living arrangement in which her interdisciplinary notes revealed she sought exit from the facility four times since admission. Observations and staff attestations revealed there was insufficient evidence to support memory care resident's clothing or briefs were not changed. Observations at the time of inspection revealed equipment was placed in front of an exit door which would prevent safe exiting of the facility in the event of fire or emergency. Review of Employee #1's file revealed she was terminated for reasons consistent with the facility's abuse and neglect policy in

	which there was lack of evidence to support resident abuse at the time of inspection. Nonetheless, the facility lacked an organized program to ensure Resident A and other memory care residents could exit the facility safely if needed. The facility lacked an organized program to ensure Resident A received personal care consistent with her admission contract, and the facility's policies. Additionally, Resident A's service plan read inconsistent with her diagnosis of Alzheimer's Dementia, as well as lacked specific care and maintenance for her exit seeking behaviors.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The memory care unit lacked two staff members on duty.

INVESTIGATION:

On 5/11/2023, the Department received a complaint through the online complaint system which read there were "*never two staff working like they are supposed to in the memory care unit*."

On 6/1/2023, I conducted an on-site inspection at the facility and interviewed Ms. DePalma who stated there were currently 65 assisted living and 15 memory care residents in the facility. Ms. DePalma stated there were three shifts, however some staff worked 12-hour shifts. Ms. DePalma stated she utilized staffing agency *Quinable* and in the meantime was actively working to hire more staff. Ms. DePalma stated on both day and afternoon shifts there were usually two medications technicians and two resident aides assigned to the assisted living unit, then two staff assigned to the memory care unit. Ms. DePalma stated sometimes one staff member assigned to the memory care unit was a medication technician; however, if not, then an assisted living medication technician would administer medications the memory care resident's medications. Ms. DePalma stated on night shift, there were two staff assigned to the assisted living unit, usually both were medication technicians and one to two staff assigned to the memory care unit. Ms. DePalma stated she assigned two staff to the memory care unit, however if staff called off work, then sometimes the unit would have one staff member. Ms. DePalma stated the expectation was for staff assigned to the assisted living to assist memory care staff, as well as relieve the staff member for breaks. Ms. DePalma stated memory care residents were ambulatory or could transfer to a walker, which was a requirement per the facility's admission contract and that the facility did not accommodate residents who required two person assist.

While on-site, I observed the memory care unit in which two staff were on duty. I observed assisted living staff were called to the unit to assist after a resident had fallen in her apartment. I observed some residents were ambulatory while others utilized wheelchairs or walkers in which most were gathered for musical activities in the dining room.

While on-site, I interviewed Employee #4 whose statements were consistent with Ms. DePalma.

I reviewed the resident roster and employee list which both read consistent with statements from Ms. DePalma.

I reviewed the facility's staff schedule dated 5/14/2023 to 6/3/2023 in which read consistent with statements from Ms. DePalma.

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 facility documentation, staff attestations and observations revealed although the memory care unit had one staff member on duty, staff assigned to the assisted living unit would also assist with resident care. Based this information, this allegation was not substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The food was cold.

INVESTIGATION:

On 5/11/2023, the Department received a complaint through the online complaint system which read the food was always cold.

On 5/15/2023, the Department received additional allegations anonymously which read food was served cold. Due to the anonymous nature of the complaint, I was unable to obtain additional information from the complainant.

On 6/1/2023, I conducted an on-site inspection at the facility and interviewed Ms. DePalma who stated there were complaints of the cold food. Ms. DePalma stated the kitchen supervisor had left in which she had just hired a new supervisor who would start in a few weeks. Ms. DePalma stated in the meantime she was the interim kitchen supervision. Ms. DePalma stated there were two cooks in the morning and one cook in the evening, along with two aides who assisted during mealtimes.

While on-site, I observed the facility's weekly menus. I observed facility's production sheets dated 5/7/2023 through 5/12/2023 which read kitchen staff were to document food's internal temperature; however, the logs were left blank for the internal temperature of food, as well as the amount of food served for various meals. I reviewed the temperature log for food served from 4/30/2023 to 5/6/2023 in which the internal temperatures for food were left blank for all meals served on 4/30/2023, then one or more meals on 5/3/2023 through 5/6/2203.

APPLICABLE RULE	
R 325.1976	**Kitchen and dietary.**
	(6) Food and drink used in the home shall be clean and wholesome and shall be manufactured, handled, stored, prepared, transported, and served so as to be safe for human consumption.
ANALYSIS:	Review of kitchen records revealed staff were to document the internal temperature of food served in which was incomplete, or left blank, thus it could not be certain that food served was at sufficient temperature for human consumption. Based on this information, this allegation was substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The facility lacked cleaning.

INVESTIGATION:

On 5/11/2023, the Department received a complaint through the online complaint system which read the housekeeping staff were not cleaning or making the beds correctly. The complaint read the rooms smelled like urine.

On 5/15/2023, the Department received additional allegations anonymously which read consistent with the complaint received on 5/11/2023. The complaint read the

bed sheets had brown and yellow stains on them. Due to the anonymous nature of the complaint, I was unable to obtain additional information from the complainant.

On 6/1/2023, I conducted an on-site inspection at the facility and interviewed Ms. DePalma who stated the housekeeping staff consisted of a working supervisor, along with four other staff and one staff person assigned to complete laundry. Ms. DePalma stated housekeeping staff worked 8:00 AM to 2:00 PM and the supervisor worked 7:30 AM to 4:00 PM. Ms. DePalma stated linens and towels were laundered at night by third shift staff and delivered to residents on day shift. Ms. DePalma stated linens were changed once weekly, however if housekeeping staff were not available, then staff could launder clothing and access the clean linens if needed.

While on-site, I observed the memory care unit and rooms lacked a urine smell. I observed approximately ten memory care resident's apartments in which the beds were made and appeared cleaned. I observed the memory care hallways and dining area appeared clean.

While on-site, I observed housekeeping staff cleaning in the memory care unit, as well as washing linens and delivering clean linens resident's rooms. I observed a memory care unit sign titled *Weekly Laundry Pick Up*. The laundry sign read the laundry procedure was for staff to place laundry bag in hall after dinner and it would be picked up after 7:00 PM, then returned the next day. The laundry sign read laundry days were as follows: 300/700 halls were Sunday, 400 hall was Monday, 500/600 were Tuesday and 800 hall was Wednesday.
While on-site, I observed the clean linen room in which the linens were folded neatly in piles and appeared laundered. Additionally, it appeared there was sufficient supply for the facility.

While on-site, I interviewed Employee #4 who stated housekeeping staff did a "good job" keeping the facility clean. Employee #4 stated staff also worked as team to ensure the facility was clean and ensured laundry was completed.

I reviewed Resident A's admission contract dated 11/8/2022 which read in part resident's received linen service and daily housekeeping including bed making.

APPLICABLE RULE	
R 325.1979	**General maintenance and storage.**
	(1) The building, equipment, and furniture shall be kept clean and in good repair.

ANALYSIS:	Review of the facility records revealed there were housekeeping staff on duty in which there was procedure for laundering of resident's clothing, linens, and towels. Observations supported the facility's records; thus, this allegation was not substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

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

06/16/2023

_____

Jessica Rogers Date
Licensing Staff

Approved By:

08/21/2023

_____

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