GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

February 02, 2024

Luke Pile
Arden Courts (Sterling Heights)
11095 14 Mile Rd
Sterling Heights, MI 48312

RE: License #: AH500293047
Investigation #: 2024A1027025
Arden Courts (Sterling Heights)

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 #:	AH500293047
Investigation #:	2024A1027025
Complaint Receipt Date:	01/23/2024
Investigation Initiation Date:	01/25/2024
Report Due Date:	03/22/2024
Licensee Name:	Arden Courts of Sterling Heights MI LLC
Licensee Address:	16th Floor 333 N. Summit St. Toledo, OH 43604
Licensee Telephone #:	(419) 252-5500
Administrator:	Elaine Chaffin
Authorized Representative:	Luke Pile
Name of Facility:	Arden Courts (Sterling Heights)
Facility Address:	11095 14 Mile Rd Sterling Heights, MI 48312
Facility Telephone #:	(586) 795-0998
Original Issuance Date:	06/09/2009
License Status:	REGULAR
Effective Date:	04/10/2023
Expiration Date:	04/09/2024
Capacity:	56
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A lacked protection and his injuries were not reported.	Yes
Additional Findings	No

III. METHODOLOGY

01/23/2024	Special Investigation Intake 2024A1027025
01/25/2024	Special Investigation Initiated - On Site
01/25/2024	Contact - Telephone call received Voicemail received from Employee #1 with additional information
01/30/2024	Contact - Telephone call made Voicemail left with Heart to Heart Hospice nurse
01/30/2024	Contact – Telephone call received Telephone interview conducted with Resident A's Heart to Heart Hospice nurse
02/02/2024	Exit Conference Conducted with Luke Pile and Elaine Chaffin by email

ALLEGATION:

Resident A lacked protection and his injuries were not reported.

INVESTIGATION:

On 1/23/2024, the Department received allegations through the online complaint system which read on 1/18/2024 Resident A was observed with bruises and two severe abrasions. The allegations read the injuries were not observed by the complainant on 1/15/2024. The allegations read Resident A's friends observed the injuries on the morning of 1/18/2024 during a Zoom call. The allegations read the injuries were reported to the complainant by Resident A's hospice nurse on 1/18/2024. The allegations read staff think the injuries occurred on 1/16/2024 or 1/17/2024; however, they were not reported.

On 1/25/2024, I conducted an on-site inspection at the facility. I interviewed Elaine Chaffin and Employee #1. Ms. Chaffin stated Resident A had progressed with

dementia since he moved into the facility in which he had declined and recently started on hospice services. Ms. Chaffin stated around Christmas time she observed Resident A started to rub his forehead on objects, such as the wall. Ms. Chaffin stated Resident A exhibited other behaviors related to his dementia such as exit seeking, and sundowning. Ms. Chaffin stated Resident A was also evaluated by Senior Psychiatry for his dementia. Ms. Chaffin stated the facility partnered with the hospice team who also notified his family of any changes.

Employee #1 stated he had not observed bleeding nor bruising on Resident A's forehead. Employee #1 stated he observed Resident A place himself from his wheelchair to the floor, then rub his head on the floor which was in his service plan. Employee #1 stated he contacted Resident A's spouse twice yesterday to update her on Resident A placing himself on the floor, as well as the abrasion above his left eye. Employee #1 stated incident reports were not completed on Resident A's injuries due to the fact Resident A's abrasions required no treatment and were not the result of a fall.

While on-site, I reviewed the incident report binder with Employee #1 who stated staff completed incident reports for incidents such as but not limited to falls, medication errors, resident altercations, or injuries that required treatment. Review of the incidents in the incident report binder read consistent with statements from Employee #1.

While on-site, I interviewed Employee #2 whose statements were consistent with Ms. Chaffin and Employee #1. Employee #2 stated she observed Resident A's abrasion on 1/16/2024 which was not bleeding nor bruised. Employee #2 stated she observed Resident A sitting on the floor without injury and reported it to Employee #1. Employee #2 stated her, and other staff reported their observations to the nurse on duty or the shift supervisor.

While on-site, I interviewed Employee #3 whose statements were consistent with previous staff interviews. Employee #3 stated she observed Resident A on 1/18/2024 during his Zoom meeting with friends and he was noted to have an abrasion on his forehead in which was open to air, lacked bruising, and appeared "*pink and fresh*."

While on-site, I observed Resident A had a quarter sized area located medially near the top of his head which appeared that the first layer of skin was removed and was dry, as well as appeared to be healing. I observed a larger area above Resident A's left eyebrow that extended the length of it in which appeared the top layer of skin was removed or rubbed off. The larger abrasion appeared moist and pink, as well as more recent than the other abrasion. I did not observe bruising on Resident A's face or forehead.

On 1/25/2024, I received a voicemail from Employee #1 in which he stated that he reviewed pictures of Resident A's abrasions from his spouse. Employee #1 stated

there was betadine on Resident A's forehead from cleaning abrasions that appeared to be bruising but was not.

On 1/30/2023, I conducted a telephone interview with Resident A's Heart to Heart Hospice nurse who stated she conducted a visit with Resident A on 1/16/2024 in which there were no abrasions observed on his forehead. Resident A's hospice nurse stated on 1/18/2024, her hospice aide visited Resident A and informed her that he had abrasions on his forehead. Resident A's hospice nurse stated she made a "*prn visit*" on 1/18/2024 to evaluate Resident A's injuries in which she observed his abrasions. Resident A's hospice nurse stated the abrasions did not require medical treatment. Resident A's hospice nurse stated she informed Resident A's spouse on 1/18/2024 who seemed upset that she was not notified by facility staff prior. Resident A's hospice nurse stated facility staff were to notify her of residents' injuries so they could be assessed and treated if necessary.

I reviewed Resident A's face sheet which read he moved into the facility on 5/19/2023. The face sheet read Relative A1 was his emergency contact and he received Heart to Heart hospice services.

I reviewed Resident A's physician orders dated 1/3/2024 which read in part Heart to Heart Hospice services were initiated.

I reviewed a form titled *Facility and Hospice Delineation of Duties* dated 1/3/2024 which read in part the facility would communicate with hospice if there was significant change in the resident's physical, mental, social, or emotional status and/or any concerns voiced by family or clinical complications that suggest need to alter the plan of care. The form read in part hospice was responsible for assessing/measuring wounds at least weekly and providing wound care supplies. The form read in part hospice and the facility were responsible for performing wound care.

I reviewed Resident A's service plan updated on 1/19/2024 which read in part Relative A1 was his responsible party. The plan read in part Resident A received safety checks hourly. The plan read in part hospice assisted with his showers. The plan read in part Resident A was at risk for a change in skin integrity in in which caregivers were to evaluate his skin condition during routine care. The plan read in part Resident A had dementia-related behavior in which he sought exits in the afternoon/evening and would rub his head on the wall or floor or stand facing the wall. The plan read in part Resident A could get very anxious in the afternoon and overnight in which staff were to identify and avoid anxiety producing situations. The plan read in part Resident A places himself on the floor and can get back up by himself. The plan read in part Resident would receive prompt medical care it the event of a fall. The plan read in part Resident A was able to transfer/ambulate but was unsteady and used a wheelchair often. The plan read in part Resident A was up during the night and sometimes not redirectable in which he would rearrange furniture and take down pictures, or the shadow boxes on the walls.

I reviewed Resident A's progress notes.

Note dated 1/15/2024 at 7:07 AM read Resident A was experiencing an unsteady gait, leaning forward as he ambulated with inability to ambulate on his own. The note read Resident A was redirected to his wheelchair to ensure safety measures. The note read hourly rounding was ongoing, physician was notified by the doctor log, and oncoming nurse was notified with the findings. The note read Resident A denied pain/discomfort, headache, or visual disturbances.

Note dated 1/17/2024 at 18:02 [6:02 PM] and effective date was 1/16/2024 at 10:30 AM read Resident A was in his wheelchair in the living room and he slid out of it onto the floor. The note read staff witnessed the incident. The note read Resident A was in an upright sitting position on the floor afterward and did not hit his head. The note read Resident A did not complain of pain or discomfort. The note read hospice, his family, and physician were notified and staff would continue to monitor.

Note for dated 1/18/2024 19:00 [7:00 PM] and effective date was 1/16/2024 at 18:30 [6:30 PM] read Resident A continues to place himself on the floor and can get up by himself. The note read Resident A was observed rubbing his head on the floor. The note read he had an abrasion on his forehead and above his left eyebrow. The note read Resident A's physician, hospice and family were made aware. The note read the areas on his forehead were cleansed and left open to air. The note read Resident A denied pain or discomfort.

Note dated 1/24/2024 16:58 [4:58 PM] read Resident A was sitting in his wheelchair in the living room of the Cottage and slide out. The note read staff were present with him and assisted him to the floor to a seated position. The note read Resident A denied pain or discomfort. The note read staff assisted Resident A back to his wheelchair. The note read Resident A family and hospice were notified.

I reviewed a hand-written progress note dated 1/16/2024 at 10:45 PM which read in part Resident A spent most of the shift sitting on the floor with objects around him. The note read in part carpet burns were observed on his forehead at the end of the shift and no other injuries were noted. The note read in part that his family would be notified and will follow up with next shift.

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.
ANALYSIS:	Review of Residents A's medical records revealed he had a diagnosis of dementia with behaviors. Staff attestations revealed Resident A's abrasions resulted from behaviors in which were consistent with his service plan and chart notes. Review of Resident A's chart notes revealed staff observed the abrasions on Resident A's forehead on 1/16/2024, and his hospice team was informed which was inconsistent with the statements from Resident A's hospice nurse. Interview with Resident A's hospice nurse revealed she observed Resident A on 1/16/2024 in which he lacked injuries at that time and was notified by the hospice aide on 1/18/2024 regarding abrasions on forehead. Resident A's nurse conducted a prn visit to assess the abrasions on 1/18/2024. Staff attestations and facility documentation revealed Resident A received protection and care consistent with his service plan. However, review of Resident A's chart notes revealed there was change in his skin integrity which was not reported to the hospice team for assessment on 1/16/2024. Therefore, the facility lacked an organized program to report a change to Resident A's licensed healthcare professional, and thus a violation was substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

01/30/2024

Jessica Rogers — Date
Licensing Staff

Approved By:

02/02/2024

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