GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

February 5, 2024

Luke Pile
Arden Courts (Livonia)
32500 W. Seven Mile Rd.
Livonia, MI 48152

RE: License #: AH820292968
Investigation #: 2024A1019025

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.

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 #:	AH820292968
Investigation #:	2024A1019025
Complaint Receipt Date:	01/18/2024
Investigation Initiation Date:	01/19/2024
Report Due Date:	03/17/2024
Licensee Name:	Arden Courts of Livonia MI, LLC
Licensee Address:	32500 W. Seven Mile Rd. Livonia, MI 48152
Licensee Telephone #:	(419) 252-5500
Administrator:	Grace Dezern
Authorized Representative:	Luke Pile
Name of Facility:	Arden Courts (Livonia)
Facility Address:	32500 W. Seven Mile Rd. Livonia, MI 48152
Facility Telephone #:	(248) 426-7055
Original Issuance Date:	05/21/2009
License Status:	REGULAR
Effective Date:	05/20/2023
Expiration Date:	05/19/2024
Capacity:	60
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Staff didn't follow procedure surrounding a resident death.	Yes
Additional Findings	No

III. METHODOLOGY

01/18/2024	Special Investigation Intake 2024A1019025
01/19/2024	Special Investigation Initiated - Telephone Called complainant to conduct interview, left voicemail requesting return phone call.
01/19/2024	APS Referral Notified APS of the allegations.
01/24/2024	Contact - Telephone call made Second call placed to complainant, left voicemail.
01/29/2024	Contact - Document Sent Emailed administrator requesting information and supporting documentation.
01/30/2024	Contact - Telephone call made Called admin to conduct interview, left voicemail requesting return phone call.
01/31/2024	Contact - Telephone call received Admin returned phone call, interview conducted.
02/01/2024	Contact - Document Received Requested information and documentation submitted by licensee.
02/01/2024	Inspection Completed-BCAL Sub. Compliance

ALLEGATION:

Staff didn't follow procedure surrounding a resident death.

INVESTIGATION:

On 1/18/24, the department received a complaint with concerns over how staff handled a resident death. The complaint read that on 1/9/24, Resident A passed away around 5:30am but staff did not call 911 until 8:30am. The complaint read that staff had no knowledge of a policy or protocol to follow when a resident dies. The complaint did not allege that any foul play occurred or that staff played a role in the resident's death.

On 1/31/24, I interviewed administrator Grace Dezern by telephone. Ms. Dezern confirmed that Resident A was found deceased by Employee 1 on the morning of 1/9/23, when she went to administer her medications. Ms. Dezern reported that Employee 1 did not know to call 911, as the resident was obviously deceased and proceeded to call the family and resident's physician. Ms. Dezern stated that facility procedure for non-hospice residents is to call 911, even if the resident already has passed away. Ms. Dezern confirmed that Resident A was not receiving hospice services.

On 2/1/24, Ms. Dezern submitted an incident report regarding the death. The incident report was authored by Employee 1 and read *"Writer went to resident room to give her meds, resident found with no vital signs. Resident was pale in color, resident was deceased. Resident husband [name omitted] notified, stated he's in Florida, resident's sister was also notified."*

The incident report listed the time of occurrence as 5:30am. The incident report listed that the resident's husband was called at 5:40am and her physician was called at 6:10am. At the bottom of the incident report, Employee 1 wrote "*Writer unaware of need to call police."*

Ms. Dezern submitted additional supporting documentation including an investigation summary report and staff statements. The investigation summary report read:

> *[Employee 1] was on duty for her shift from 11pm -7 am on 1/8/2024. When passing the medications at 5:50 am on 1/9/2024 she found [Resident A] in her room unresponsive. She called the doctor, husband [name omitted], and residents' sister to notify them of [Resident A's] passing. At 7am the shift change occurred; [Employee 2] started her shift at 7:00 am. [Employee 1] informed her of the passing of [Resident A] and left for the day. [Employe 2] and Grace Dezern Executive Director, called the husband to see what funeral home he wanted to his wife to go to. He informed them that he did not have one in place and to call his daughter, she asked us if we knew of one nearby. The Executive Director*

recommend she find one and call us once she knew where her mom would be going. Time had lapsed between the passing and waiting for the daughter to call back. It was approximately 1 hour before she called back with the name and number of the funeral home. [Employee 2] put the funeral home representative on speaker so the Executive Director can hear. [Employee 2] informed the funeral home where we were located to pick up the body. The Funeral home asked if the Medical Director or 911 was called to signed off on the death. At that time [Employee 3] came in the health center and overheard the representative and asked [Employee 2] and Executive Director Grace Dezern if 911 was called. Grace Dezern called [Employee 1] to ask her if she had called 911, she stated no she did not know she had to being the resident had a DNR in place. The ambulance did come to the community, a police officer came shortly after, the office did ask why the nurse did not call 911. I let him know that I did call her, and she stated she did not know she had to call with a DNR. The office asked the Executive Director if the MD [name omitted] would sign off on the death certificate which he did. [Employee 1] was counseled on the protocol of calling 911 if a resident is unresponsive and not on hospice.

Employee 1's signed statement read:

I was the nurse on duty 1/8/24 1pm until 7am 1/9/24. I went to residents room 59 to give her the am medications at approximately 5:30am. Upon arrival the resident was found with no vital signs. The resident was pale in color, resident was deceased, resident was a DNR. The MD was notified, husband [name omitted] who stated he was in Florida, and residents sister [name omitted]. I was unaware of the need to call 911. I notified the day shift nurse at the beginning of her shift at 7:00am that the resident was deceased and the funeral home was not called.

Employee 2's statement read:

On January 9, 2024 I came into work at 7AM and was notified by midnight nurse that resident in room 59 [Resident A] had passed away. The executive director, Grace and I called [Resident A's] spouse. He informed us to notify his daughter for a funeral home, I called requested funeral home, and was asked if the medical director was called for a time of death, at that time [Employee 3] walked in the health center and overheard the conversation and asked me if 911 was called. At that time myself and the executive director did not see medical personal [sic]. The executive director immediately called 911 after not having a medical examiner number. Emergency personal [sic] showed up along with the police officer, he asked why 911 was not called after finding the resident deceased. I told the police officer I was unsure as to why the nurse on duty at that time did not notify 911 emergency. I gave the officer the name and number of [Employee 1] who was on duty for the midnight shift. The officer gave me a report number for the police report, he then left the facility. The funeral home came to pick up the residents body shortly thereafter.

Employee 4's statement read *"I was the caregiver that worked on Boat house 1/8/24 7pm until 7am 1/9/24. I did my rounds and observed resident breathing at 4:15am. The nurse came at 5:30am and told me that resident had expired. I went to do post morten [sic] care on the resident."*

Ms. Dezern clarified that the post mortem care Employee 4 provided was "*to dress her and clean her after she passed*".

Ms. Dezern's statement read:

> *I came into work approximately 7:15am, upon arrival to do my rounds I checked in with the morning nurse [Employee 2] and midnight nurse [Employee 1] who were both in the health center. [Employee 1] notified me that [Resident A] had passed away early that morning. [Employee 1] informed me that the family was notified as well as the doctor. I asked both nurses if the funeral home was called to pick up the body, the reply was not yet. It was shift change so [Employee 1] left and [Employee 2] called the husband back to see what funeral home the body was to go to. The husband stated he did not have a funeral home in mind and to please call his daughter. [Employee 2] and I called the daughter, she asked us if we knew of a funeral home in the area. I replied no, that she should google and find one she would like to have her mom moved to. She returned the call within the hour and gave [Employee 2] the information. When the nurse called the funeral home to puck up the body, the representative at the funeral home asked for a Medical Examiner number while on speaker. [Employee 3] then walked in the health center for her shift. After hearing the funeral home wanted the medical examiner number and hearing us say we do not have one, [Employee 3] asked if 91 was called. I then called [Employee 1] to ask her if she did call 911, she stated no, she was not aware she had to being she was already deceased. I immediately called 911 to report the resident had passed. The officer came shortly after the ambulance and asked why 911 was not called at [sic] time resident was discovered deceased. I informed him that I spoke with the nurse who state she was not aware she had to call 911 because resident was deceased and had a DNR in place. The police asked for our doctor's number to see if he would sign the death certificate. The doctor did sign.*

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:	Facility staff failed to follow proper protocol by contacting emergency medical services to pronounce the resident's death; the death certificate could not be signed until the death was confirmed by the appropriate parties.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

02/01/2024

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Elizabeth Gregory-Weil Date
Licensing Staff

Approved By:

02/05/2024

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