GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 04, 2024

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

RE: License #: AH500236728
Investigation #: 2024A1027038
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 #:	2024A1027038
Complaint Receipt Date:	03/13/2024
Investigation Initiation Date:	03/13/2024
Report Due Date:	05/12/2024
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:	01/28/2024
Expiration Date:	07/31/2024
Capacity:	136
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Residents did not receive their medications on time.	Yes
Residents lacked regular showers. Residents were not bathed and cleaned after being soiled.	Yes
Staff handled residents in a “rough manor.”	No
Additional Findings	No

The complainant identified some concerns that were not related to licensing rules and statues for a home for the aged. Therefore, only specific items pertaining to homes of the aged provisions of care were considered for investigation. The following items were that that could be considered under the scope of licensing.

III. METHODOLOGY

03/13/2024	Special Investigation Intake 2024A1027038
03/13/2024	Special Investigation Initiated - Telephone Voicemail left with APS' referral source/complainant
03/19/2024	Inspection Completed On-site
03/26/2024	Inspection Completed-BCAL Sub. Compliance
04/04/2024	Exit Conference Conducted by email with Lou Petroni and Fran DePalma

ALLEGATION:

Residents did not receive their medications on time.

INVESTIGATION:

On 3/13/2024, the Department received allegations forwarded from Adult Protective Services (APS) which read staff were not administering residents’ medications on time. APS did not open investigation pertaining to the allegations.

On 3/13/2024, I left voicemail with the complainant in which no return call was received.

On 3/19/2024, I conducted an on-site inspection at the facility. I interviewed Employee #1 who stated medications were to be administered one hour before or after the time they were written to be administered by the licensed healthcare professional. Employee #1 stated there were no complaints from residents or their families regarding medication administration.

I reviewed four randomly selected residents' March 2024 medication administration records (MARs). I also reviewed the medication administration history for each of their prescribed medications.

Review of Resident A's MAR revealed for one or more doses of medication on 3/1/2024 and 3/6/2024 were left blank. Resident A's medication administration history read some medications were to be administered at 9:00 AM and were documented as administered from 6:50 AM to 7:48 AM. Additionally, the history read some medications were to be administered at 9:00 PM and were documented as administered within that timeframe; however, on 3/16/2024 medications were documented as administered at 5:13 PM without a recorded exception.

Review of Resident B's MAR revealed for one or more doses of medications on 3/10/2024 were left blank. Resident B's medication administration history read some medications were to be administered at 9:00 AM and documented as administered starting at 7:40 AM. The history read some medications were to be administered at 9:00 PM and some were documented as administered starting at 5:13 PM without a recorded exception.

Review of Resident C's MAR revealed she was prescribed Risperidone, take one tablet every 12 hours at 8:00 AM and 8:00 PM in which staff documented the medication was unavailable on 3/1/2024 for both doses, and for the morning doses on the following dates 3/2/2024, 3/3/2024, 3/5/2024 through 3/9/2024, however, the medication was documented as administered for the evening doses on those dates as well as both doses on 3/4/2024. Review of Resident C's medication administration history revealed some medications were to be administered at 8:00 AM and some were documented as administered starting at 9:37 AM without a recorded exception. The history read some medications were to be administered at 8:00 PM and some were documented as administered starting at 5:31 PM and 9:37 PM without recorded exceptions.

Review of Resident D's medication administration history revealed her medications were to be administered at 8:00 AM and 8:00 PM, and some medications were documented as administered at 11:00 AM and 5:32 PM without a recorded exception.

I reviewed the general guidelines for medication administration which read in part "*administer medications 1 hour before, or not more than 1 hour after the prescribed schedule*."

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(2) Prescribed medication managed by the home shall be given, taken, or applied pursuant to labeling instructions, orders and by the prescribing licensed health care professional.
ANALYSIS:	Review of randomly audited residents' MARs and medication history reports revealed medications were not always administered as prescribed by the licensed healthcare professional and within the facility's guidelines; therefore, this allegation was substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Residents lacked regular showers. Residents were not bathed and cleaned after being soiled.

INVESTIGATION:

On 3/13/2024, the Department received allegations forwarded from APS which read residents did not receive regular showers. The allegation read residents were not bathed and cleaned fully after becoming soiled. APS did not open investigation pertaining to the allegations.

On 3/13/2024, I left voicemail with the complainant in which no return call was received.

On 3/19/2024, I conducted an on-site inspection at the facility. I interviewed administrator Fran DePalma who stated some residents refused showers in which the facility's policy was to contact their authorized representative after a few times of refusing showers to provide notification of the refusals. Ms. DePalma stated there was a shower logbook where staff documented that showers were completed.

I interviewed Employee #1 whose statements were consistent with Ms. DePalma. Employee #1 stated there was a shower logbook for both assisted living and memory care residents. Employee #1 stated a few residents required "depends"

checks in which staff were to document the checks were completed in the Quick MAR (medication administration record) system.

I interviewed Employee #2 whose statements were consistent with previous staff interviews. Employee #2 stated staff on her shift consistently changed residents' briefs and provided incontinence care. Employee #2 stated residents received their showers regularly and often they would "do makeup showers." Employee #2 stated staff were apprised of the residents who would wet heavy in their briefs in which they would be changed more frequently.

I observed 36 assisted living and 18 memory care residents who all appeared well groomed and were in clean clothing. Additionally, the facility smelled clean.

I reviewed Resident A, B, C and D's March 2024 shower records. Resident A's shower records read he completed showers himself on Monday mornings. Resident B's shower records read she received showers on Saturday evenings in which the following dates were left blank 3/2/2024 and 3/9/2024. Resident C's shower records read she received showers on Friday evenings and were documented as completed on the following dates 3/1/2023, 3/8/2024, and 3/15/2024. Resident D's shower records read she received showers on Monday and Thursday mornings which were documented as completed on the following dates 3/4/2024, 3/7/2024, 3/13/2024, and 3/18/2024. Resident D's shower record read she was in the hospital on 3/11/2024. Additionally, I reviewed the shower logbook for four other randomly selected residents in which the shower records were incomplete and left blank various dates.

I reviewed Resident E's records in which she required depends checks every four hours. The records read staff documented her depends checks every four hours for March 2024, or recorded an exception as to why the checks were not completed such as she was out of the facility.

APPLICABLE RULE	
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.

ANALYSIS:	Staff attestations revealed residents regularly received showers and incontinence care. Additionally, staff attestations revealed residents were placed on the shower schedule and staff were to document the showers in the shower logbook. Review of depends check records revealed it read consistent with staff attestations. However, review of residents' shower records revealed some dates were left blank in which it could not be confirmed if showers were received or not; therefore, this allegation was substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Staff handled residents in a "*rough manor*."

INVESTIGATION:

On 3/13/2024, the Department received allegations forwarded from APS which read staff handled residents in a "rough manor."

On 3/13/2024, I left voicemail with the complainant in which no return call was received.

On 3/19/2024, I conducted an on-site inspection at the facility. I interviewed the administrator Fran DePalma who stated she had no had residents nor residents' family submit complaints regarding the care from staff.

I interviewed Employee #1 whose statements were consistent with Ms. DePalma. Employee #1 stated staff were trained to treat residents like they were family. Employee #1 stated she had not observed, witnessed nor had any staff or resident report abuse. Employee #1 stated staff were trained on dementia, as well as abuse and neglect. Employee #1 stated in addition to initial staff training, other agencies presented training to their staff to provide additional education and reinforcement of previously learned skills. Employee #1 stated for example, a home care agency recently presented to staff about dementia care.

I interviewed Employee #2 who stated she had not observed or witnessed staff provide care in a "rough manor." Employee #2 stated she felt the residents were well cared for by herself and other staff.

I observed 18 memory care residents who all appeared well cared for and staff interacted positively with them.

I reviewed the facility's training program for staff. The program included the Resident Abuse (Physical/Sexual) Policy which read in part anyone observing a violation of the policy is required to report it to their immediate supervisor or the Administrator. The policy read in part that the facility would investigate and take appropriate corrective action, including disciplinary measures, up to and including discharge. The training program included a copy of the Resident Rights and Responsibilities for staff to keep. The training program also included videos and written training on Alzheimer's Disease, communicating with residents who have Alzheimer's Disease, wandering, resisting care, agitation, aggression, and anger.

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents; adoption; posting and distribution; contents; additional requirements; discharging, harassing, retaliating, or discriminating against patient exercising protected right; exercise of rights by patient's representative; informing patient or resident of policy; designation of person to exercise rights and responsibilities; additional patients' rights; definitions.**
	(2) The policy describing the rights and responsibilities of patients or residents required under subsection (1) shall include, as a minimum, all of the following: **(l) A patient or resident is entitled to be free from mental and physical abuse and from physical and chemical restraints, except those restraints authorized in writing by the attending physician or a physician's assistant to whom the physician has delegated the performance of medical care services for a specified and limited time or as are necessitated by an emergency to protect the patient or resident from injury to self or others, in which case the restraint may only be applied by a qualified professional who shall set forth in writing the circumstances requiring the use of restraints and who shall promptly report the action to the attending physician or physician's assistant. In case of a chemical restraint, a physician shall be consulted within 24 hours after the commencement of the chemical restraint.**

ANALYSIS:	Staff attestations, observations and review of the facility's staff training program revealed there was insufficient evidence to support this allegation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

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

03/26/2024

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Jessica Rogers Date
Licensing Staff

Approved By:

04/03/2024

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