GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 29, 2024

Daniel Fessler
Arden Courts (Livonia)
32500 W. Seven Mile Rd.
Livonia, MI 48152

RE: License #: AH820292968
Investigation #: 2024A0784048
Arden Courts (Livonia)

Dear Daniel Fessler:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

Please review the enclosed documentation for accuracy and contact me with any questions. If I am not available, and you need to speak to someone immediately, please contact the local office at (517) 284-9730.

Sincerely,

Aaron L Clum

Aaron Clum, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 230-2778

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH820292968
Investigation #:	2024A0784048
Complaint Receipt Date:	04/16/2024
Investigation Initiation Date:	04/16/2024
Report Due Date:	06/15/2024
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 Dezen
Authorized Representative:	Daniel Fessler
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:	05/20/2024
Expiration Date:	07/31/2024
Capacity:	60
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Inadequate supervision of Resident A	Yes
Additional Findings	No

III. METHODOLOGY

04/16/2024	Special Investigation Intake 2024A0784048
04/16/2024	Special Investigation Initiated - Telephone Interview with complainant
04/17/2024	Inspection Completed On-site
05/29/2024	Exit – Email Report sent

ALLEGATION:

Inadequate supervision of Resident A

INVESTIGATION:

On 4/16/2024, the department received this online complaint.

According to the complaint, Resident A has had several falls in the last four months since he has lived at the facility. Resident A recently fell sustaining injuries. Resident A mostly falls during the nighttime due to not being checked on enough by staff.

On 4/16/2024, I interviewed Complainant by telephone. Complainant stated Resident A is a person with dementia. Complainant stated Resident A is unable to walk on his own and requires a wheelchair for ambulation but is still very physically active in that he will often try to get out of his wheelchair by himself and in turn, is at a high risk for falls. Complainant stated Resident A does not understand that he is unable to walk on his own and has a very low awareness of his own safety. Complainant stated Resident A “is a very proud person” and will try to use the restroom on his own without asking staff for assistance. Complainant stated Resident A can sometimes walk with a walker, but that he is very unsteady and should not do so without someone behind him. Complainant stated that during family visits, family will walk behind Resident A with his wheelchair behind him while he

walks with his walker in case he falls back. Complainant stated it has been suggested to put Resident A on a regular toileting schedule throughout the night but that it is unknown if staff check on him to do so. Complainant stated Resident A "fidgets" a lot and has been attempting to stand on his own more. Complainant stated Resident A's attempts to stand are unpredictable. Complainant stated there is concern Resident A may have a fall with even more serious injuries. Complainant stated Resident A's recent fall was on 4/14/2024. Complainant stated Resident A fell forward out of his wheelchair in his room hitting the right side of his face and leaving a large bruise around his eye.

On 4/17/2024, I interviewed administrator Grace Dezern at the facility. Ms. Dezern stated Resident A is very active and does not sit still. Ms. Dezern stated Resident A can walk but does not see well and is very weak on his feet. Ms. Dezern stated, "all day long he will try to get up on his own" and that sometimes "it feels like it is every minute of every day". Ms. Dezern stated Resident A is often up at night and is a wanderer. Ms. Dezern stated staff are supposed to check on Resident A at least every hour.

On 4/17/2024, I interviewed wellness director Gina Hickman at the facility. Ms. Hickman provided statements consistent with those of Ms. Dezern. Ms. Hickman stated the facility has had a meeting with Resident A's family recently and that staff have been instructed to check on Resident A at least every thirty minutes during the day and night. Ms. Hickman stated that even with the additional frequency of checks, Resident A is such a high fall risk, lacking safety awareness, it may not be enough as he will try to get up at any time Ms. Hickman stated discussions have been had with family about possibly getting a one-on-one caretaker for Resident A during the nighttime, but no decision has been made on that as of yet.

On 4/17/2024, I conducted an onsite at the facility. I observed Resident A sitting in his wheelchair in his room with Relative A present. Resident A's movements were consistent with those described by complainant as he moved a lot in his chair and continually attempted to grab items off the table in his room. I observed a large bruise around Resident A's right eye covering the area around his cheek bone to the side of his eye and above his eyelid. I was unable to interview Resident A related to his diagnosis of Dementia. I interviewed Relative A while at the facility. Relative A stated family visits often during the daytime. Relative A stated the biggest concern is that Resident A is up a lot at night and will often attempt to get up on his own. Relative A stated Resident A can stand but is very weak on his feet and is likely to have a fall.

I reviewed Resident A's service plan provided by Ms. Hickman. Under a section titled *AMBULATION & TRANSFERRING*, the plan reads, in part, "Able to transfer/ambulate resident needs stand by assist with walking. Safer in a wheelchair". Under a section titled *TOILETING-BLADDER MANAGEMET*, the plan reads, in part, "He needs full assistance as he is a fall risk. Monitor every 30 mins". Under a section titled WANDERING, the plan reads, in part, "Safety checks hourly".

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.**
R 325.1922	**Admission and retention of residents.**
	(5) A home shall update each resident's service plan at least annually or if there is a significant change in the resident's care needs. Changes shall be communicated to the resident and his or her authorized representative, if any.
ANALYSIS:	The complaint alleged Resident A has had several falls due to a lack of adequate supervision. When interviewed, Ms. Dezern and Ms. Hickman both described Resident A consistently with Complainant in that Resident A is a person who is a very high fall risk with very low safety awareness. Resident A was described as someone who is very active and often attempts to get up at night. While the facility increased Resident A's wellness checks to every thirty minutes, the increase in monitoring is not sufficient for the supervision of Resident A based on his described behaviors and statements provided by complainant, Ms. Dezern and Ms. Hickman. Additionally, while the frequency at which Resident A is supposed to be monitored was increased to every thirty minutes, at least one section of Resident A's service plan was not updated indicating he needs "Safety checks hourly". Based on the findings, the facility is not in compliance with these rules.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, it is recommended that the status of the license remain unchanged.

5/28/2024

Aaron Clum — Date
Licensing Staff

Approved By:

05/29/2024

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