GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 5, 2024

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

RE: License #: AH820292968
Investigation #: 2024A0784052
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 #:	2024A0784052
Complaint Receipt Date:	04/30/2024
Investigation Initiation Date:	04/30/2024
Report Due Date:	06/30/2024
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:	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:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Inadequate supervision	Yes
Additional Findings	No

III. METHODOLOGY

04/30/2024	Special Investigation Intake 2024A0784052
04/30/2024	Special Investigation Initiated - Letter Referral to APS
04/30/2024	APS Referral
05/01/2024	Inspection Completed On-site
05/29/2024	Contact - Document Sent Email sent to administrator Grace Dezern. Request/Follow up on previously requested documents
06/04/2024	Contact - Document Received Email received with additional document request
7/05/2024	Exit - Email Report sent to administrator

ALLEGATION:

Inadequate supervision

INVESTIGATION:

On 4/30/2024, the department received this online complaint from Detective McKailey Scott of the Livonia Police Department. A referral was made to adult protective services (APS).

According to the complaint on 4/26/2024 at 6:30am, Resident A was attacked in her room" with a plastic garbage can, striking her in the face repeatedly" by Resident B. Resident A's "injuries were limited to bleeding and swelling, she was transported to the hospital for evaluation but later released". While Resident B has been moved to

a different hallway in the facility, there is concern that his supervision is not adequate.

On 5/01/2024, I interviewed administrator Grace Dezern at the facility. Ms. Dezern stated that the incident with Resident A and Resident B happened on the morning of 4/26/2024 at approximately 6:30am. Ms. Dezern stated that on that morning, Associate 1 was working third shift on Resident A's hallway. Ms. Dezern stated Associate 1 had just assisted Resident A with toileting and went to another resident's room to help them get up for the day. Ms. Dezern stated Associate 1 reported that when she came out of that resident's room, she heard someone yelling "get out of my room" in Resident A's room and went to see what was going on. Ms. Dezern stated that upon entering the room, Associate 1 observed Resident B hitting Resident A with an object. Ms. Dezern stated Associate 1 was able to get Resident B to leave Resident A's room and immediately called the nurse, Associate 2 who was working in the building in another hallway, from her walkie talkie and requested assistance. Ms. Dezern stated Associates 1 and 2 stayed with Resident A and tended to her bloody nose. Ms. Dezern stated Associate 2 also contacted police and emergency medical services (EMS). Ms. Dezern stated Resident A was taken to the hospital and Resident B was moved to a different hallway and, as a corrective measure, staff were instructed to check on Resident B every 30 minutes and that if he is observed wandering outside of his room, to ensure they are aware of where he is at. Ms. Dezern stated the hallways that Resident A and Resident B are in are not secured from one another and Resident B is able to get back to the Resident A's hallway. Ms. Dezern stated a "special lock" was placed on Resident A's door which does not lock from the inside so she can get out but does not allow anyone to wander into her room. Ms. Dezern stated both Residents are diagnosed with advanced dementia. Ms. Dezern stated that prior to this incident, Resident B was a known wanderer but had not been proactively violent toward anyone. Ms. Dezern stated Resident B did sometimes wander into other resident rooms believing it was his room but was able to be easily re-directed. Ms. Dezern stated Resident B would periodically start looking for his wife and get agitated but was able to be de-escalated by staff. Ms. Dezern stated Resident A had once previous incident in which another male resident attacked him and he defended himself, but that he was not the aggressor.

On 5/01/2024, I interviewed wellness director Gina Hickman at the facility. Ms. Hickman provided statements consistent with those of Ms. Dezern. Ms. Hickman stated that on 4/29/2024, Resident A was sent to Beaumont Hospital for a psychological evaluation. Ms. Hickman stated he was sent back the same day with no changes to his medications. Ms. Hickman stated Resident B is scheduled for a more comprehensive psychological evaluation.

On 5/01/2024, I observed Resident A sitting on a couch in the common area of the hallway her room is in called Boat House. I observed bruising to the right side of Resident A's face and cheek. Resident A appeared calm and well groomed. I

observed Resident B sitting on a couch in the common area of the hallway his room is on called Cottage Hall. Resident B appeared calm and well groomed.

I reviewed Resident A's service plan, provided by Ms. Hickman. Under a section titled Wandering, the plan read, in part, "Safety checks every 30 mins".

I reviewed facility *Progress Notes* specific to Resident B between December 2023 and April 2024, provided by Ms. Hickman. Notes dated 12/14/2023 read, in part, "Resident was being combative with the caregiver as he was trying to assist resident in getting dressed and struck the caregiver on his face with his fist". Notes dated 1/25/2024 read, in part, "Caregiver came to me to inform me there was an altercation with Residents [Resident B and Resident C] Altercation taken place in [Resident C's] room. [Resident B] was observed on [his] back on the bed [Resident C] on top of him pending [pinning] his hands on the bed. Writer separated resident and took him to his room and assessed him". Notes dated 3/01/2024 read, in part, "care giver came to inform writer that [Resident D] and [Resident B] were going back and forth arguing when [Resident D] approached [Resident B] and grabbed him and [Resident B] bitten [Resident D] on his right forearm".

I reviewed April 2024 staff *24 HOUR REPORT* notes for Resident A, provided by Ms. Hickman. Notes dated 4/09/2024 read, in part, "went in [Resident E's] room thinking it's his". Notes dated 4/14/2024 read, in part, "very aggressive today since this morning during dinner time". Notes dated 4/15/2024 read, in part, "going to people rooms". Notes dated 4/17/2024 read "check N changed very confused. Combative".

I reviewed Resident B's psychological assessment, provided by Ms. Hickman. The date provided on the assessment indicated it was completed on 5/06/2024. According to the assessment, Resident A was given a diagnosis of "Vascular dementia with behavioral disturbance". Under a section titled *Plan*, the assessment read, in part, "No medication changes. Closely monitor patient's condition and adjust meds accordingly".

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:	The complaint alleged a lack of adequate supervision to protect Resident A after Resident B attacked her in her room on 4/26/2024 leaving injuries to her face. While the administrator and wellness director reported Resident A did not have a history of behavior that would have revealed the possibility of such an incident, review of facility reports indicated that prior to the incident, on at least two occasions, Resident B presented with an increase in aggression and behaviors. Given that Resident B had presented with increased aggression and behaviors, it would have been reasonable to expect the facility to begin seeking assistance at that time. Ultimately, Resident B's behavior and aggression increased to the point at which he attacked Resident A in her own room leaving injuries to her face. Based on the findings, the allegation is substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

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

6/12/2024

Aaron Clum — Date
Licensing Staff

Approved By:

07/05/2024

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