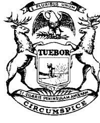

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

MARLON I. BROWN, DPA
DIRECTOR

December 12, 2024

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

RE: License #: AH820292968
Investigation #: 2025A0784010
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 #:	2025A0784010
Complaint Receipt Date:	11/14/2024
Investigation Initiation Date:	11/14/2024
Report Due Date:	01/13/2025
Licensee Name:	Arden Courts of Livonia MI, LLC
Licensee Address:	32500 W. Seven Mile Rd. Livonia, MI 48152
Licensee Telephone #:	(419) 252-5500
Administrator:	Taja Savelle-McKnight
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:	08/01/2024
Expiration Date:	07/31/2025
Capacity:	60
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Inadequate medical attention for Resident A	Yes
Additional Findings	No

III. METHODOLOGY

11/14/2024	Special Investigation Intake 2025A0784010
11/14/2024	Special Investigation Initiated - Telephone Attempted contact with phone number provided for complainant. Message left. Name provided on the voicemail did not match name provided in complaint
11/15/2024	Inspection Completed On-site
11/15/2024	Contact - Telephone call made Attempted with phone number provided for complainant
11/19/2024	Contact - Document Received Email received from employee 1 and administrator Taja-Savelle McKnight with attached document.
11/21/2024	Contact - Document Sent Email sent to administrator and employee 1 with request for re-request for documents/information request onsite as initial documents provided did not include several items requested onsite
11/22/2024	Contact - Document Received Investigative documents/info received from administrator
11/25/2024	Contact - Document Sent Email sent to administrator
11/25/2024	Contact - Document Received Email response from administrator
12/12/2024	Exit - Email Report sent

ALLEGATION:

Inadequate medical attention for Resident A

INVESTIGATION:

On 11/14/2024, the department received this online complaint.

According to the complaint, on 11/05/2024, the facility reported Resident A was sent to the hospital due to not being able to urinate. Resident A was found to have seven fractured ribs and a punctured lung. Staff at the facility were unable to provide any details regarding Resident A's status. No resident or staff names were provided in relation to this complaint.

On 11/15/2024, I interviewed employee 1, and a supervisor at the facility. Administrator Taja-Savelle McKnight was present during the interview. Employee 1 confirmed that Resident A was transferred to the hospital on 11/05/2024 via emergency medical services (EMS). Employee 1 stated that Resident A had reportedly been suffering from urinary retention and had consistently expressed pain in his stomach and back. Employee 1 stated that when the facility became aware that Resident A was discovered to have fractures in his ribs and a punctured lung, an investigation was done regarding the events leading up to Resident A going to the hospital.

Employee 1 reported the following about what was discovered after interviewing several staff; On 11/04/2024, employee 2 came into work around approximately 11:30am and Resident A was complaining of pain in his stomach and back. Employee 3, a supervisor and nurse, was made aware of Resident A's reported pain and was given a Tylenol which was common for Resident A as he regularly complained of pain, especially in his stomach and sometimes his back. Employee 2 and employee 4, later in the shift on 11/04/2024, assisted Resident A with shaving and he was still complaining of pain, so they laid him down in bed. Resident A did not want to get up for dinner that evening and was still complainant of pain. When employee 5 arrived to start her shift at 7pm on 11/04/2024, employee 3 informed her that Resident A had been complainant of pain in his back. Upon doing rounds, employee 5 observed Resident A laying across his bed with his feet hanging over the side. Employee 5 came back around to check on Resident A a little while later and he was still in the same position. Employee 5 then helped Resident A to reposition in his bed, to lay length wise in the bed. When doing this, Resident A rolled over and yelled out like something hurt. Employee 5 reported this to employee 6, a supervisor and nurse. Upon doing early rounds, at approximately 5am, on 11/05/2024, employee 5 observed Resident A on the floor in his room crawling toward the bathroom. Employee 5 notified employee 7, a nurse and supervisor who worked the night shift, and contacted employee 8 to assist getting Resident into bed. Employee 8 reported that upon entering Resident A's room, Resident A was on his knees complaining of back pain and a headache. Employee 7 gave Resident A

some Tylenol. Employee 5 decided to transfer Resident A into a wheelchair and have him sit in the common area so staff could observe him closely. Upon coming in for a morning shift on 11/05/2024, at 7am, employee 4 noticed Resident A sitting in the wheelchair. When employee 4 asked about this, as it was not normal for Resident A to be in a wheelchair, employee 4 was told by employee 5 Resident A could not walk so employee 5 and employee 7 had placed him in the wheelchair. Employee 4 ambulated Resident A, in the wheelchair, to breakfast. Resident A ate approximately %70 of his breakfast, but was reportedly moaning and yelling out "somebody help me". Employee 4 asked Resident A what was wrong, but he could not answer and was holding his midsection. Employee 9, a nurse and supervisor, was also aware of Residents reported pain at this time. After breakfast, employee 10 assisted Resident A to the restroom. Resident A struggled to urinate only producing dribbles and again complained of pain in his stomach. Resident A fell asleep in the wheelchair in the common area and slept until lunch. When employee 4 woke Resident A up, he was talking some but also continued to moan in pain. Resident A also would not eat lunch so employee 4 notified employee 9 of Resident A's continued pain and lack of appetite. Employee 9 gave Resident A some Tylenol. At approximately 3pm on 11/05/2024, Employee 10 assisted Resident A with the restroom again and Resident A still struggled to produce urine. Employee 10 reported this to employee 9 who discussed Resident A's symptoms with employee 11, the oncoming nurse and supervisor, at which time the decision was made to have Resident A transferred to the hospital. Employee 1 stated several staff provided written statements.

Employee 1 stated that at baseline, it was common for Resident A to complain of some stomach pain and maybe some pain in his body and that Tylenol would usually work for him. Employee 1 stated, however, it was not common for Resident A to express the kind of pain observed and reported to nurses by staff. Employee 1 stated Resident A could normally walk on his own and did not sleep in a chair during the day as he was, so he was displaying behavior out of his baseline. Employee 1 stated that when Resident A was discovered on his floor in his room and this was reported to employee 7, an incident report should have been created and employee 7 should have contacted Resident A's physician at that time for further guidance. Employee 1 stated it was not acceptable that Resident A continued to display pain and behaviors out of the ordinary and that it took so long for staff to seek additional medical attention. Employee 1 stated actions would be taken to address this.

I reviewed written statements from employees 2,3,4,7,8,10 and 11 which read consistently with statements provided by employee 1.

APPLICABLE RULE	
R 325.1921	**Employees; general provisions.**
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.
ANALYSIS:	The complaint alleged Resident A was discovered to have several fractured ribs and a punctured lung and that the facility did not appropriately seek medical attention. The investigation confirmed Resident A's injures and revealed that even though Resident A expressed physical pain and behaviors outside of his baseline on 11/04/2024, staff did not take appropriate action to seek medical attention until 11/05/2024. Based on the findings, the allegation is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

12/11/2024

Aaron Clum — Date
Licensing Staff

Approved By:

12/12/2024

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