GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 3, 2026

Jennifer Herald
Arbor Grove Assisted Living & Memory Care
1320 Pine Avenue
Alma, MI 48801

RE: License #: AH290406205
Investigation #: 2026A1028038
Arbor Grove Assisted Living & Memory Care

Dear Jennifer Herald:

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 responsible party 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 I am not available, and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

Julie Viviano, Licensing Staff
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

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

## I. IDENTIFYING INFORMATION

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|---|---|
| **License #:** | AH290406205 |
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| **Investigation #:** | 2026A1028038 |
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| **Complaint Receipt Date:** | 03/11/2026 |
| | |
| **Investigation Initiation Date:** | 03/11/2026 |
| | |
| **Report Due Date:** | 05/10/2026 |
| | |
| **Licensee Name:** | 1320 Pine Avenue Opco LLC |
| | |
| **Licensee Address:** | 4500 Dorr Street<br>Toledo, OH 43615 |
| | |
| **Licensee Telephone #:** | Unknown |
| | |
| **Administrator:** | Amanda Raglin |
| | |
| **Authorized Representative:** | Jennifer Herald |
| | |
| **Name of Facility:** | Arbor Grove Assisted Living & Memory Care |
| | |
| **Facility Address:** | 1320 Pine Avenue<br>Alma, MI 48801 |
| | |
| **Facility Telephone #:** | (989) 463-3074 |
| | |
| **Original Issuance Date:** | 06/02/2021 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 08/01/2025 |
| | |
| **Expiration Date:** | 07/31/2026 |
| | |
| **Capacity:** | 62 |
| | |
| **Program Type:** | AGED<br>ALZHEIMERS |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Staff leave residents in dirty and soiled clothing. | No |
| The facility is short-staffed. | No |
| Staff do not receive appropriate training. | No |
| There are medication errors such as pills being found on the floor of a resident's room, medications put in applesauce, and medications and ointments being found in resident rooms without orders. | Yes |
| Additional Findings | Yes |

## III. METHODOLOGY

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|---|---|
| 03/11/2026 | Special Investigation Intake<br>2026A1028038 |
| 03/11/2026 | Special Investigation Initiated - Letter |
| 03/11/2026 | APS Referral |
| 03/19/2026 | Contact - Face to Face<br>Interviewed the facility administrator at the facility. |
| 03/19/2026 | Contact - Face to Face<br>Interviewed Employee A at the facility. |
| 03/19/2026 | Contact - Face to Face<br>Interviewed Employee B at the facility. |
| 03/19/2026 | Contact - Document Received<br>Received requested paperwork from the facility administrator. |

This investigation will only address allegations pertaining to potential violations of the rules and regulations for Homes for the Aged (HFA). The complaint was submitted anonymously to the HFA department with no identifying resident information and no identifying complainant or contact information. Due to the complainant being anonymous, the complainant could not be interviewed for this special investigation and additional identifying information could not be obtained. Please note that HFA

facilities do not provide skilled services. Please note that HFA rules and regulations do not require staff that work in the home to have license(s) or certification(s) to be eligible to work in the home. Please note that the HFA department does not address issues or conflict(s) between the employer and employee.

**ALLEGATION:**

**Staff leave residents in dirty and soiled clothing.**

**INVESTIGATION:**

On 3/11/2026, the Bureau received the allegations anonymously through the online complaint system.

On 3/19/2026, I interviewed the administrator at the facility who reported residents are not left soiled or dirty and that this behavior would not be tolerated at the facility. The facility administrator reported there are a few residents who are incontinent with bowel and/or bladder, but those residents are on a toileting schedule; and that there have been no issues with those residents.

On 3/19/2026, I interviewed Employee A at the facility whose statement was consistent with the facility administrator's statement.

On 3/19/2026, I interviewed Employee B at the facility whose statement was consistent with the facility administrator's statement.

On 3/19/2026, I completed an onsite inspection due to this special investigation, and no smell of urine or feces was detected in the facility. Also, residents observed were well groomed, clean, and being appropriately assisted by staff. No concerns were noted during the inspection.

| **APPLICABLE RULE** | |
|---|---|
| **R 325.1931** | **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:** | It was alleged that staff leave residents in dirty and soiled clothing. Interviews and the onsite investigation revealed there is no evidence to support this allegation. No violation found. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

**ALLEGATION:**

**The facility is short-staffed.**

**INVESTIGATION:**

On 3/19/2026, the facility administrator reported that while call-ins occur, the facility is not short staffed. The facility has mandation if a call-in occurs. There are also on-call staff and management to assist to prevent a short shift as well. There are 9 residents in the memory care unit and 33 residents in the assisted living unit. The facility administrator reported that first and second shifts have 5 care staff assigned and third shift has 3 care staff assigned. Call-lights are answered in a timely manner, and the facility expectation is that call-lights are answered within 5 minutes. The facility administrator provided me with the requested documentation for my review.

On 3/19/2026, Employee A's statement was consistent with the facility administrator's statement.

On 3/19/2026, Employee B's statement was consistent with the facility administrator's statement.

On 3/19/2026, I completed an inspection of the facility due to this special investigation and observed an appropriate number of staff assisting residents with care.

On 3/19/2026, I reviewed the requested documentation which revealed the following:
Review of the from January 2026 to March 2026 working staff schedules:

- Call-ins occurred from 1/1/2026 to 3/19/2026, but there was evidence of staff coverage for each call-in to prevent a short shift.
- There was evidence of mandation to prevent a short shift.
- There was evidence of call-in staff and management assisting to prevent a short shift.

Review of the call-light logs from January 2026 to March 2026:

- The overall average call-light time per week ranged from 6 to 11 minutes from the time the call-light was activated to the time the call-light was turned off by staff.

| **APPLICABLE RULE** | |
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| **R 325.1931** | **Employees; general provisions.** |
| | **(5) The home shall have adequate and sufficient staff on duty at all times who are awake, fully dressed, and capable** |

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| | **of providing for resident needs consistent with the resident service plans.** |
| **ANALYSIS:** | It was alleged the facility is short staffed. Interviews, onsite investigation, and review of documentation reveal there is no evidence to support this allegation. The facility demonstrates an appropriate number of staff assigned and working in the facility to meet the needs of the residents and to prevent a short shift if a call-in occurs. No violation found. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

**ALLEGATION:**

**Staff do not receive appropriate training.**

**INVESTIGATION:**

On 3/19/2026, the facility administrator reported all staff are trained at onboarding and receive additional training throughout the year to ensure competency. Training is provided through online courses, hands-on practice, through competency completion and testing, through third-party training sessions etc. The facility administrator provided me with the requested documentation for my review.

On 3/19/2026. Employee A's statement and Employee B's statement were consistent with the facility administrator's statement.

On 3/19/2026, I reviewed the training documentation for the 4 new employees that were completing the onboarding process. No concerns were noted during the review of the training documents.

| **APPLICABLE RULE** | |
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| **R 325.1931** | **Employees; general provisions.** |
| | **(6) The home shall establish and implement a staff training program based on the home's program statement, the** |

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| | **residents service plans, and the needs of employees, such as any of the following:**<br>**(a) Reporting requirements and documentation.**<br>**(b) First aid and/or medication, if any.**<br>**(c) Personal care.**<br>**(d) Resident rights and responsibilities.**<br>**(e) Safety and fire prevention.**<br>**(f) Containment of infectious disease and standard precautions.**<br>**(g) Medication administration, if applicable.** |
| **ANALYSIS:** | It was alleged that staff do not receive appropriate training. Interviews, onsite investigation, and review of documentation reveal there is no evidence to support this allegation. The facility demonstrates an appropriate training program based on the home's program statement, the residents service plans, and the needs of employees etc. No violation found. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

**ALLEGATION:**

**There are medication errors such as pills being found on the floor of a resident's room, medications put in applesauce, and medications and ointments being found in resident rooms without orders.**

**INVESTIGATION:**

On 3/19/2026, the facility administrator reported knowledge of medication being found in Resident A's room on the floor. The facility administrator was unsure of the exact date but reported during the time of this onsite investigation that it occurred within the last 2 weeks. However, no documentation was recorded on the incident. The facility administrator reported that all medications placed in applesauce or any other palatable substance have a physician order to do so. No resident is provided medication in applesauce or other palatable substance(s) unless there is a physician order in place. The facility administrator reported that to [their] knowledge there are no medications or ointments in resident rooms. All medications require a physician's order and are kept locked in the medication cart if staff assist residents with medication administration.

On 3/19/2026, Employee A confirmed that medication was found on the floor in Resident A's room. It could not be determined which medication was found because it was suspected that Resident A pocketed the medication in their cheek, did not swallow it when administered, and later spit it out on the floor and staff found it later.

Employee A reported that staff are supposed to ensure that medication administered to any resident in the facility is swallowed entirely and not pocketed in the cheek or spit out. Employee A reported [they] were unable to determine what medication was found by staff and on which shift the incident occurred, but reported it occurred within the last 2 weeks. Employee A reported staff were re-educated during a staff meeting on the importance of ensuring appropriate medication administration, however, Employee A confirmed no documentation was completed on the incident. Employee A also confirmed that no resident is provided with medication in applesauce or any other palatable substance(s) unless there is a physician order in place. Employee A also confirmed that all medications have a physician order and are kept locked in the medication cart and that residents do not have medications or ointments in their rooms.

On 3/19/2026, Employee B's statement was consistent with the facility administrator's statement and Employee A's statement. Employee B showed me the current physician orders for residents that receive medications in applesauce or another palatable substance for my review. No concerns were noted during this review.

| **APPLICABLE RULE** | |
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| **R 325.1932** | **Resident medications.** |
| | **(2) Prescribed medication managed by the home must be given, taken, or applied pursuant to labeling instructions, orders and by the prescribing licensed healthcare professional.** |

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| **ANALYSIS:** | It was alleged that there are medication errors such as pills being found on the floor of a resident's room, medications put in applesauce, and medications and ointments being found in resident rooms without orders. Interviews, onsite investigation, and review of documentation reveal the following:<br><br>There is no evidence to support that medications and ointments are in resident rooms without orders.<br><br>The is no evidence to support that medications are placed into applesauce for administration without a physician order in place.<br><br>However, interviews revealed that medication was found on the floor of Resident A's room on an unknown date. No documentation was recorded on this incident, therefore, it cannot be determined if Resident A received medication in accordance with physician orders. Therefore, the facility is in violation. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**ADDITIONAL FINDINGS:**

On 3/19/2026, the facility administrator reported that the incident in which medication was found on Resident A's floor was not documented.

On 3/19/2026, Employee A and Employee B confirmed that pills were found on the floor of Resident A's room on an unknown date within the last 2 weeks. Employee A and Employee B also confirmed that staff are trained to ensure medication is swallowed and that residents do not pocket medication in their cheek, spit medication out, or hide medication in their mouth during administration.

| **APPLICABLE RULE** | |
|---|---|
| **R 325.1932** | **Resident medications.** |
| | **(3) If a home or the home's administrator or direct care staff member supervises the taking of medication by a resident,** |

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| | **then the home shall comply with all of the following provisions:**<br>**(a) Be trained in the proper handling and administration of medication.**<br>**(b) Complete an individual medication log that contains all of the following information:**<br>**(vi) A resident's refusal to accept prescribed medication or procedures.**<br>**(g) Upon discovery, contact the resident's licensed health care professional if a medication error occurs. A medication error occurs when a medication has not been given as prescribed.** |
| **ANALYSIS:** | During the onsite investigation, it was discovered that no documentation was completed by staff when medication was found on the floor of Resident A's room. Due to this, it cannot be determined when the incident occurred, what staff member(s) were involved, if staff notified Resident A's physician or authorized representative of the medication refusal, or if staff were provided re-education and re-training on medication administration procedures to ensure medication is not pocketed in the cheek, under the tongue or spit out by the resident. Therefore, the facility is in violation. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

## IV. RECOMMENDATION

Contingent upon receipt of an approved corrective action plan, I recommend the status of this license remains the same.

Julie Viviano

3/30/2026

Julie Viviano Date
Licensing Staff

Approved By:

04/02/2026

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