RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

January 4, 2018

Barbara Exel
Addington Place
42010 W Seven Mile Road
Northville, MI 48167

RE: License #: AH820378951
Investigation #: 2017A1013023
Addington Place

Dear Ms. Exel:

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 that I am not available and you need to speak to someone immediately, please contact the local office at (248) 975-5053.

Sincerely,

Loma M Campbell, Licensing Staff
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(248) 860-3110

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH820378951
Investigation #:	2017A1013023
Complaint Receipt Date:	02/13/2017
Investigation Initiation Date:	02/13/2017
Report Due Date:	04/15/2017
Licensee Name:	ARHC APNVLMI01 TRS, LLC
Licensee Address:	C/O ARC HC Trust ll, Coun 405 Park Ave, 14th Floor New York, NY 10022
Licensee Telephone #:	(212) 415-6551
Administrator:	Barbara Exel
Authorized Representative:	Barbara Exel
Name of Facility:	Addington Place
Facility Address:	42010 W Seven Mile Road Northville, MI 48167
Facility Telephone #:	(248) 305-9600
Original Issuance Date:	02/10/2016
License Status:	TEMPORARY
Effective Date:	02/10/2016
Expiration Date:	08/09/2016
Capacity:	80
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established
Resident eloped from the facility.	Yes
Additional Findings	Yes

III. METHODOLOGY

02/13/2017	Special Investigation Intake 2017A1013023
02/13/2017	APS Referral Telephoned APS Centralized Intake to make referral
02/13/2017	Special Investigation Initiated - Telephone Telephoned APS Centralized Intake to make referral
02/16/2017	Inspection Completed On-site On-site inspection included interviewing staff members and residents, reviewing record, and observing environment
02/21/2017	Contact - Telephone call made Telephoned staff members Anitha Boyd, Janet Marshall, and Doris Ann Henry
12/18/2017	Contact - Document Sent Requested police report
12/19/2017	Contact - Document Received Received police report
01/04/2018	Exit Conference Conducted with Sheri Emery, by telephone

ALLEGATION:

Resident eloped from the facility.

INVESTIGATION:

On 2/10/17, I received a voicemail from supervisor of resident care Doris Ann Henry reporting that Resident A had eloped from the facility at 6:10 pm, on 2/10/17.

On 2/16/17, I reviewed Resident A's record at the facility. Resident A moved into Addington Place on 1/23/17 with a diagnosis of dementia.

Resident A's service plan dated 1/23/17 included behavioral interventions to address anxiety and restless which included the use of as needed medications after several methods and interventions had been attempted. The methods included staff to offer activity such as folding clothes, running vacuum, taking resident for a walk, etc.

On 2/21/17, I interviewed supervisor of resident care Doris Ann Henry by telephone. Ms. Henry stated that she was working on 2/10/17 from 3:00 pm until 11:00 pm and staff members Anitha Boyd and Janet Marshall were working on the Devonshire House unit where Resident A resided.

On 2/21/17, I interviewed Ms. Boyd by telephone. Ms. Boyd stated that she was in Resident B's room assisting Resident B when a door alarm sounded. Ms. Boyd said she came out of Resident B's room, went to the back door where the alarm sounded, opened the back door, did not see anyone, returned immediately inside, informed Ms. Marshall to do a room check of all residents on the Devonshire House unit and went to the other living units in the building to inform the staff members that a resident was out of the building. Ms. Boyd said she figured that Resident A had left the building because when she went into Resident B's room, Resident A was sitting in the common area of Devonshire House unit where the couch and television is located. Ms. Boyd stated that she had provided Resident A with one to one staffing before entering Resident B's room because Resident A was trying to leave the building. Ms. Boyd said she then informed all the other staff members working in the building to complete a count of the residents as well as to check the building for Resident A. Ms. Boyd explained that Resident A had attempted to leave the facility previously and the behaviors escalates after the dinner meal.

On 2/21/17, I interviewed Ms. Marshall by telephone. Ms. Marshall stated when the incident occurred she was in the dining/satellite kitchen area cleaning up the dining area. Ms. Marshall's statements were consistent with Ms. Boyd's statements concerning the incident.

Ms. Henry stated that a count of the residents was done, and Resident A was not located in the building. Ms. Henry stated that she and staff members Rebecca Spencer, Nakila Hill-Albright, and Ms. Boyd checked the exterior of the building and did not see Resident A.

On 2/16/17, I interviewed staff members Nakila Hill-Albright, Rebecca Spencer, Domini Pearson, Samone Stewart, and LaBreshia Harden at the facility. Ms. Hill-Albright, Ms. Spencer, Ms. Pearson, Ms. Stewart, and Ms. Harden stated that they were working from 3:00 pm until 11:00 pm on 2/10/17 and their statements concerning the counting of the residents as well as checking of the exterior of the facility were consistent with Ms. Henry's and Ms. Marshall's statements.

The Northville Township Police Department Report dated 2/10/17 read in a section titled information that "At approximately 1830 hrs [6:30 pm], an unknown female came into NTPD lobby escorting [Resident A]. According to the unknown female she was driving down Seven Mile Rd and observed [Resident A] walking down the road appearing to be "disoriented." The unknown female pulled over and put [Resident A], who was freezing, into her vehicle to transport her to NTPD…had NTFD respond to the lobby to conduct a medical evaluation of [Resident A]. While NTFD conducted medical evaluation…had dispatch contact Addington Place…to see if they had any walkaways [sic]. Addington Place informed dispatch that they just had a walkaway [sic] and gave a description that matched [Resident A]...NTFD completed their evaluation and determined she was medically fine…transported [Resident A] to Addington Place…"

Ms. Henry stated that Resident A was returned to the facility at about 7:10 pm on 2/10/17 by a Northville Township Police Department police officer.

APPLICABLE RULE	
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 of providing for resident needs consistent with the resident service plans.
ANALYSIS:	Resident A had demonstrated behaviors of attempting to leave the building before the actual elopement on 2/10/17. The two staff members who were working the Devonshire House unit were not attending to Resident A but were completing other tasks. The facility did not have adequate staffing on duty to address Resident A's elopement risk.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION:

The service plan dated 1/23/17 included that Resident A was a high risk for elopement. However, specific methods and staff interventions to address the behaviors were not included in the service plan.

APPLICABLE RULE	
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:	Resident A's service plan was not updated to include that Resident A demonstrated behaviors of elopement nor the interventions necessary to keep her safe.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 1/04/2018, I conducted an exit conference with support assistant Sheri Emery by telephone. Ms. Emery stated that she was filling in for the authorized representative Barbara Exel while Ms. Exel is on a medical leave of absence. Ms. Emery had no comments.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the status of the license.

Loma M Campbell 1/04/2018

Loma M Campbell Date
Licensing Staff

Approved By:

Russell Misiak 1/4/18

Russell B. Misiak Date
Area Manager