RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

August 9, 2018

Sheri Emery
Addington Place
42010 W Seven Mile Road
Northville, MI 48167

RE: License #: AH820378951
Investigation #: **2018A0585017**
Addington Place

Dear Ms. Emery:

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.

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,

Brender Howard, Licensing Staff
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(313) 268-1788

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH820378951
Investigation #:	2018A0585017
Complaint Receipt Date:	05/01/2018
Investigation Initiation Date:	05/03/2018
Report Due Date:	07/31/2018
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:	Sheri Emery
Authorized Representative:	Sheri Emery
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:	REGULAR
Effective Date:	08/10/2017
Expiration Date:	08/09/2018
Capacity:	80
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
The facility moved Resident G from the Carrington Unit to the Bradford Unit without her belongings.	Yes
Facility left resident with an ingrown toenail which caused her pain. Nobody noticed that she had it.	Yes
Medication was not being managed correctly to address Resident's G pain and she was given Tylenol instead of required Tramadol.	No

III. METHODOLOGY

05/01/2018	Special Investigation Intake 2018A0585017
05/03/2018	Special Investigation Initiated - Letter APS referral form completed (Andrea)
05/03/2018	APS Referral Andrea provided initial allegations to APS by telephone
05/03/2018	Contact - Telephone call received APS centralized unit - Ashley (Andrea)
05/14/2018	Inspection Completed On-site Interviews completed, observations made, and record reviewed,
05/14/2018	Exit was conducted with Authorized Representative Barbara Exel.

ALLEGATION:

The facility moved Resident G from the Carrington Unit to the Bradford Unit without her belongings.

INVESTIGATION:

On 5/1/18, the department received a complaint with multiple allegations via BCAL Online Complaints.

On 5/3/18, the allegations were reported to Adult Protection Service (APS) by Licensing Staff Loma Campbell.

On 5/13/18, I interviewed the complainant by telephone. The complainant stated that Resident G is being neglected at the facility. She stated that the resident is a higher functioning dementia patient. She stated that Resident G also suffers with chronic back pain and the facility does not managed the resident's pain medication to address her pain. She stated that the resident's pain got worse due to staff not monitoring her pain. The complainant stated that the resident was moved from the Carrington unit of the facility to the Bradford unit. The complainant stated that the administrator had asked in the past about moving Resident G to the Bradford unit and she told them no. She stated that she never gave them permission to move the resident. She stated that the resident was confused and did not know where she was. She stated that the resident's belonging was still in the Carrington unit and she did not have any of her personal things with her when they took her down to the Bradford unit.

On 5/14/18, I interviewed the administrator Barbara Exel at the facility. Ms. Exel stated that Resident G was always at the door knocking to get out. She stated that they were concerned that she was mean toward others. We moved Resident G to watch her in the common area of the Bradford unit. She stated that the family members were not happy about it. She stated that Resident G thought the facility were her house. Ms. Exel stated that the resident was escorted by staff to Bradford unit upon waking up and coming out of her room in Carrington, during the day, as she was being verbally aggressive with other ambulatory residents and pointing her finger in the resident's face.

On 5/14/18, I interviewed Regional Director Sheri Emery at the facility. Ms. Emery stated that they decided to move Resident G to Bradford unit and her daughter did not like it. She stated that they did it for a couple of days. She stated they were attentive to Resident G's pain and they tried to work with her. Ms. Emery stated that they thought it was the best thing to do and they talked to the family.

I interviewed Director of Nursing Jude LeBlanc who stated that resident and family members was threatened by Resident G's behavior. She stated that the resident was not physically, but she was verbally aggressive to others. She stated she would tell others to get out of her house. Ms. LeBlanc stated that they would take Resident G to the Bradford unit during waking hours.

I reviewed pictures sent to our department of Resident G sitting in the Bradford unit in a wheelchair, along with other residents.

On 5/15/18, I reviewed the service plan for Resident G. The service plan showed that Resident G has challenging behaviors which includes anxiety and have needs to be kept busy. The plan read that Resident G was diagnosed with dementia, although she is identified as high functioning, she was confused and had a hard time carrying on a conversation. Resident G had a Power of Attorney.

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents;**
	(1) A health facility or agency that provides services directly to patients or residents and is licensed under this article shall adopt a policy describing the rights and responsibilities of patients or residents admitted to the health facility or agency. Except for a licensed health maintenance organization which shall comply with chapter 35 of the insurance code of 1956, 1956 PA 218, MCL 500.3501 to 500.3580, the policy shall be posted at a public place in the health facility or agency and shall be provided to each member of the health facility or agency staff. Patients or residents shall be treated in accordance with the policy.
For Reference: MCL 333.20201	**(c) A nursing home patient or home for the aged resident is entitled to retain and use personal clothing and possessions as space permits, unless to do so would infringe upon the rights of other patients or residents, or unless medically contraindicated as documented in the medical record by the attending physician or a physician's assistant to whom the physician has delegated the performance of medical care services. Each nursing home patient or home for the aged resident shall be provided with reasonable space. At the request of a patient, a nursing home shall provide for the safekeeping of personal effects, funds, and other property of a patient in accordance with section 21767, except that a nursing home is not required to provide for the safekeeping of a property that would impose an unreasonable burden on the nursing home.**
ANALYSIS:	Based on interview, the resident moved the resident to another unit in the home without notifying the guardian of the resident that resident was being moved. Although the facility felt that this was the right thing to do, they failed to notify responsible party of the resident.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Facility left resident with an ingrown toenail which caused her pain. Nobody noticed that she had it.

INVESTIGATION:

Relative G1 stated that Resident G had an ingrown toe nail that the facility failed to cut. She stated that when she asked the facility on 2/19/18 about it, their respond was that it would not be until March when the Podiatrist services is offered again.

I reviewed the shower sheets for Resident G for February and March. The shower sheet for 3/1/18, notes that the resident had an ingrown toenail. No other dates noted an ingrown toenail.

On 08/07/18, I interviewed the Executive Director Ashley Dubay by telephone. Ms. Dubay stated that the facility provides nail trimming on Saturdays and as needed. She also stated that care partners are not allowed to trim toenails because some of the residents may by diabetic. Ms. Dubay stated that if there is an ingrown toe nail, they have an in-house podiatrist that trims and treats the nails.

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:	Resident G is dependent upon staff for personal care. The facility staff were aware Resident G had an ingrown toe nail and suffered discomfort. While the facility has a policy that care staff are not allowed to provide nail care, they do have an onsite podiatrist, but staff did not coordinate care to meet Resident G's needs.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Staff failed to properly read Resident's chart and provide proper medications and care causing her anxiety to escalate, becoming agitated and her pain to increase. Tylenol was given instead of required Tramadol.

INVESTIGATION:

Relative G 1 stated that there were no management of Resident G's needs. She stated that resident's pain management was not being cared for and as a result, she would become agitated and have the alleged confrontations with others.

On 5/14/18, I interviewed Med Tech Tamara Johnson. Ms. Johnson stated that Resident G's pain was managed. She stated that the daughter of the resident would go out to the doctor and get the resident shots in the back. She stated they give the resident her as needed (prn) medications when she needs it.

On 5/15/18, I reviewed notes from *Senior Psychiatric Services of Michigan* dated 3/12/18 for Resident G. The notes showed good medication compliance. The notes also read that no gradual dose reduction (GDR) recommended and any changes made to psychiatric medications at this time would be detrimental to patient's mental health and are clinically contraindicated.

A review of the Resident's Medical Administration Record (MAR) showed that Resident G had an order for Tramadol for pain one tablet by mouth every eight hours as needed for breakthrough pain. The MAR showed various days that Tramadol was given for pain.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(4) If a resident requires medication while out of the home, then the home shall assure that the resident, or the person who assumes responsibility for the resident, has all of the appropriate information, medication, and instructions.
ANALYSIS:	Inspection of MAR's and documentation revealed medication was properly given to Resident G as ordered. Based on these findings allegation could not be substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

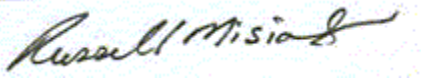
On 5/14/18, I shared the findings of this report with the licensee authorized representative Barbara Exel at the facility. Ms. Exel did not make any comments about the allegations. As of the date of this report, 8/9/18, Ms. Exel is no longer the authorized representative.

IV. RECOMMENDATION

8/8/18

Brender Howard — Date
Licensing Staff

Approved By:



8/8/18

Russell B. Misiak — Date
Area Manager