GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 29, 2019

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

RE: License #: AH820378951
Investigation #: **2019A1022001**
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 (616) 356-0100.

Sincerely,

Barbara Zabitz, Licensing Staff
Bureau of Community and Health Systems
350 Ottawa, N.W. Unit 13, 7th Floor
Grand Rapids, MI 49503
(313) 296-5731

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH820378951
Investigation #:	2019A1022001
Complaint Receipt Date:	12/26/2018
Investigation Initiation Date:	01/02/2019
Report Due Date:	01/25/2019
Licensee Name:	ARHC APNVLMI01 TRS, LLC
Licensee Address:	C/O ARC HC Trust II, Coun 405 Park Ave, 14th Floor New York, NY 10022
Licensee Telephone #:	(212) 415-6551
Administrator:	Ashley Dubay
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:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Staff do not know how to prevent infections from spreading from resident to resident.	Yes
Additional Findings	Yes

III. METHODOLOGY

12/26/2018	Special Investigation Intake 2019A1022001
01/02/2019	Special Investigation Initiated - Telephone
01/04/2019	Contact - Document Sent
01/08/2019	Inspection Completed On-site
01/17/2019	Contact - Telephone call made Interview administrator
01/17/2019	Inspection Completed-BCAL Sub. Compliance
\01/29/2019	Exit Conference Authorized Representative Sheri Emery.

ALLEGATION:

Staff do not know how to prevent infections from spreading from resident to resident.

INVESTIGATION:

On 1/2/19, I interviewed the complainant by telephone. The complainant explained that Resident A was brought to the dining room after having an episode of severe

diarrhea. The complainant was worried that Resident A was contagious and should not have been seated among the other residents where she exposed others to possible infection. The complainant was also concerned that Resident D might have shingles and that Resident D was not isolated either. The complainant identified that both Resident A and Resident D resided in the Bradford unit of the facility.

On 1/4/2019, I notified Adult Protective Services of the complainant's concerns.

On 1/8/19, I first interviewed administrator Ashley Dubay and regional director Sheri Emery at the facility. Ms. Emery explained that she was very proud of this facility because they offered an onsite licensed nurse 24 hours per day, seven days a week as well as a physician who was in the building on a weekly basis. Ms. Dubay described residents living on the Bradford unit as being highly dependent on the caregivers for activities of daily living.

I asked Ms. Dubay to describe the expectations of facility staff when a resident presented with symptoms of diarrhea and/or changes in condition. According to Ms. Dubay, the caregiver who observed the diarrhea (or other change) was to note its presence on the unit 24-hour report and to inform the medication passer. The medication passer was to report the episode to the nurse in the building for that particular shift and was to administer an anti-diarrheal medication as specified in the facility's standing orders. At the end of the shift, the out-going nurse was to pass the information about the episode to the on-coming nurse. The nurse who was assigned to the day shift was to report out the information at the morning staff meeting to all staff present.

Ms. Dubay and I then reviewed each of the *24-hour* reports for the month of December 2018 for the Bradford unit. According to this documentation, Resident A, Resident B, and Resident C all experienced multiple episodes of diarrhea during the month.

We next reviewed each of the *Nurse-to-Nurse* reports for the month of December 2018. These reports documented only two episodes of diarrhea. The report for 12/23/18 documented an episode for Resident A, which was consistent with the 12/23/18 Bradford unit *24-hour* report. The *Nurse-to-Nurse* Report for 12/29/18 documented an episode for Resident C, which was not consistent with the 12/29/18 Bradford unit *24-hour* report. The 12/29/18 Bradford unit *24-hour* report made no mention of an episode of diarrhea for Resident C.

Ms. Dubay and I next reviewed the facility's morning staff meeting notes for the month of December 2018. This report made no mention of episodes of diarrhea for residents on the Bradford unit with the exception of a notation for Resident B for the meeting held on 12/18/18. This episode was not noted on the Bradford *24-hour* report for 12/18/18 nor on the *Nurse-to-Nurse* report for the same date.

We then reviewed December 2018 Nurses' Notes for Resident A, Resident B, and Resident C. The only documentation regarding diarrhea was for Resident A, noting the episode of diarrhea this resident experienced on 12/23/18.

Lastly, we reviewed the list of residents referred to the facility physician for the month of December 2018. There were no referrals to the physician for any residents from the Bradford unit for the evaluation of diarrhea. According to the facility's *Standing Orders* for their residents, staff were to "Notify Physician if symptoms are not resolved in 48 hours." It was unclear if any of the resident met this criterion.

I then interviewed the director of nursing, Jude Leblanc. Ms. Leblanc stated that she "never looks" at the individual units' *24-hour* reports and she depends upon caregivers verbally telling her of unusual symptoms or other changes in condition; or if the information is documented in the *Nurse-to-Nurse* report; or if it is brought up at the morning meeting. Ms. Leblanc then stated that she had "no knowledge" of any resident living on the Bradford unit with diarrhea or loose stools.

When Ms. Leblanc was asked to identify any residents living on the Bradford unit with a rash, Ms. Leblanc stated that Resident D had been diagnosed with shingles. Ms. Leblanc stated that on 12/22/18, Ms. Leblanc noticed a rash on the right side of Resident D's neck and notified the on-call physician. Ms. Leblanc stated that to her, this rash looked like shingles. According to Ms. Leblanc, the on-call physician made a medication order and when Ms. Leblanc asked if the area needed to be covered, the on-call physician replied that it did not. Ms. Leblanc then stated that all staff were using contact precautions with Resident D. Ms. Leblanc described contact precautions as wearing gloves and washing hands when done. Resident D was seen by the facility's nurse practitioner on 12/27/18. The nurse practitioner confirmed the diagnosis of shingles and prescribed additional medication.

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.**
For Reference: **R 325.1901**	**Definitions.**
	(16) "Protection" means the continual responsibility of the home to take reasonable action to ensure the health, safety,

	and well-being of a resident as indicated in the resident's service plan, including protection from physical harm, humiliation, intimidation, and social, moral, financial, and personal exploitation while on the premises, while under the supervision of the home or an agent or employee of the home, or when the resident's service plan states that the resident needs continuous supervision.
ANALYSIS:	The facility lacked an organized method to reasonably compile data from disparate sources including the *24-hour*, *Nurse-to-Nurse*, and *morning meeting* reports. The facility was unable to assemble a complete picture of the prevalence of diarrhea among residents residing on the Bradford unit. These residents may have required further evaluation of their symptoms. My analysis of resident episodes, compiled from all data sources, shows that Resident C had documented diarrhea on three consecutive days, 12/27 through 12/29/18, and met the criterion within the facility's standing orders for physician evaluation. However, staff did not follow the order as they did not have an organized program to compile the data collected.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Jude Leblanc explained that all staff used contact precautions when caring for Resident D, who had been diagnosed with shingles. When I asked to see Resident D, I was accompanied to the Bradford unit by Ms. Leblanc and Ms. Dubay.

After entering the room occupied by Resident D, both Ms. Leblanc and Ms. Dubay donned disposable gloves. Neither individual washed hands prior to putting the gloves on. Ms. Leblanc manipulated Resident D's hair, so that her rash was visible. Ms. Dubay took a washcloth to wipe away food that was on Resident D's face. Both individuals then removed their gloves and only then washed their hands.

I then interviewed Bradford unit medication passer Ivory Brown. Ms. Brown was asked to describe the steps she took when she provided care to a resident who required contact precautions. Ms. Brown stated that she would put on a pair of gloves; provide the care; remove the gloves; wash her hands; and then dispose the gloves. Ms. Brown did not indicate that she would wash her hands prior to donning the gloves.

I then asked Ms. Dubay for an outline of the curriculum used to train facility caregivers regarding hand hygiene and contact precautions. Ms. Dubay responded that she did not have an outline because all training was done via an online proprietary training program. When I asked Ms. Dubay if the facility had any written policies on hand hygiene or contact precautions, Ms. Dubay produced two documents. The first, entitled "infection Control," with review dates of 3/10/17 and 7/10/18 read "This facility will require staff to wash their hands after each direct resident contact." However, the second document, entitled "Infection Control – Universal Precautions," also dated as reviewed on 3/10/17 and 7/10/18, read "Wash your hands before and after each resident contact." Both Ms. Dubay and Ms. Leblanc stated that they were not aware that the facility had two policies that were in conflict with each other and not aware that their facility's practice on hand hygiene did not meet widely accepted standards of practice.

The World Health Organization issues guidance for glove use and hand hygiene at the following website https://www.who.int/gpsc/5may/Glove_Use_Information_Leaflet.pdf and advises that hand washing occur both before donning and after removing gloves.

APPLICABLE RULE	
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 residents service plans, and the needs of employees, such as any of the following: **(f) Containment of infectious disease and standard precautions.**
ANALYSIS:	The facility lacked the ability to ensure that all employees were trained and utilized the widely accepted practice of washing one's hands prior to resident contact and prior to donning gloves.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 1/29/19, I shared the findings of this report with the authorized representative Sheri Emery by phone. Ms. Emery did not make any comments about the findings.

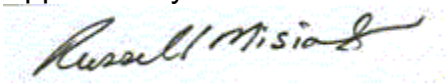
IV. RECOMMENDATION

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

1/29/19

Barbara Zabitz — Date
Licensing Staff

Approved By:



1/29/19

Russell B. Misiak — Date
Area Manager