GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

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

June 27, 2019

RE: License #: AH820378951
Investigation #: 2019A1011042 - 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 licensee authorized representative 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,

Andrea Krausmann, Licensing Staff
Bureau of Community and Health Systems
51111 Woodward Avenue 4th Floor, Suite 4B
Pontiac, MI 48342
(586) 256-1632

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH820378951
Investigation #:	2019A1011042
Complaint Receipt Date:	05/13/2019
Investigation Initiation Date:	05/13/2019
Report Due Date:	07/12/2019
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:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A ingested another resident's medications.	Yes
Resident A obtained the medications because they were left unattended by staff.	Yes
Additional Findings	Yes

III. METHODOLOGY

05/13/2019	Special Investigation Intake 2019A1011042
05/13/2019	Special Investigation Initiated - Telephone Called complainant - unavailable. Left name/number requesting call back.
05/13/2019	APS Referral Submitted referral to adult protective services (APS) providing allegations via email.
05/13/2019	Contact - Document Received APS intake worker Tina Marie Hilgeman emailed confirmation that my APS referral was received.
05/13/2019	Contact - Telephone call received Interviewed complainant.
05/16/2019	Contact - Telephone call received Assigned APS worker Nicole Asberry called. She is heading to hospital to meet resident.
05/17/2019	Contact - Document Received Complainant emailed list of medications that the resident received in error and that the resident is still hospitalized. POA refused pacemaker implantation - valid DNR order in place.
05/25/2019	Contact - Document Received Email from complainant clarifying contact information.
06/03/2019	Contact - Telephone call received

	Assigned APS worker Nicole Asberry left voice mail requesting call back.
06/03/2019	Contact - Telephone call made Returned call to Nicole Asberry APS worker. Informed me of her investigation.
06/03/2019	Contact - Telephone call received APS worker Nicole Asberry called back and updated me of her investigation.
06/21/2019	Inspection Completed On-site Interviews conducted, observations made, and records reviewed.
06/21/2019	Contact - Telephone call made Left voice mail message for Doris Ann Henry requesting interview.
06/21/2019	Contact - Telephone call made Left voice mail message for Donyl Snead requesting interview.
06/21/2019	Contact - Telephone call received Doris Ann Henry LPN returned my call - interview conducted.
06/21/2019	Contact - Telephone call received Donyel Snead Life Enrichment returned my call - interview conducted.
06/21/2019	Contact - Document Sent Email to Sheri Emery and Ashley Dubay requesting Nurse Practitioner Kathleen Step's phone number.
06/21/2019	Contact - Document Received Email at 9 pm from Ashley Dubay with Nurse Practitioner Kathleen Step's office phone number.
06/24/2019	Contact - Telephone call made Called Ms. Step’s office. Spoke with Susan Swaffar. She will obtain information and call me back.
06/24/2019	Contact - Telephone call made Called administrator Ashley Dubay for additional documentation.
06/24/2019	Contact - Document Received Ashley Dubay emailed Resident A’s history and physical dated 11/20/18 and Resident A’s power of attorney documentation.

06/24/2019	Contact – Telephone call received Susan Swaffar of Ms. Step's office called back with information.
06/24/2019	Contact – Telephone call made Left message for Jude LeBlanc requesting follow up interview.
06/24/2019	Contact – Telephone call received Follow-up interview with Ms. LeBlanc.
06/27/2019	Exit Conference – Conducted with licensee authorized representative Sheri Emery via telephone.

ALLEGATION:

Resident A ingested another resident's medications.

INVESTIGATION:

On 5/13/19, I received the allegations via the online intake unit. I interviewed the complainant by telephone and made a referral to adult protective services (APS).

According to the complainant, on 5/11/19 at 9:00 am a resident ingested another resident's medications. The facility called 911 at 2:25 pm. The Northville Twp. fire department was dispatched, and the female resident was pale, drowsy and lethargic. The resident was alert to verbal stimuli and was her normal mental status according to staff. The complainant said a facility staff nurse name Jude reported that another resident's medications were left on a counter for an unknown amount of time. The resident came upon the countertop and ingested the other resident's medications orally. The complainant said Jude also reported that the resident did not receive her correct medications that morning. The resident's pulse was found to be strong but bradycardic. She was administered four separate doses of atropine 0.5 mg intravenously. The first time her heart rate increased to 48 but then decreased back to the high 30s and low 40s. At which time she received a second dose that increased her heart rate again but then decreased after 3 - 7 minutes. The process was implemented four times, with the resident receiving 2 mg of atropine in total. She was taken into the emergency room.

On 5/17/19, the complainant emailed that the resident was still in the hospital as of 5/13/19, and her power of attorney had refused pacemaker implantation. The complainant reported that the resident received the following medications in error:

Sertraline 50 mg
Trazodone 50 mg
Vitamin D3 2000 units
Calcium 500 mg

Clonidine HCL 0.1mg
Hydrochlorothiazide 25 mg
Ibuprofen 600 mg
Levothyroxine 100 mcg
Metoprolol 50 mg

I reviewed an incident report submitted to the department by the facility on 5/13/19, pertaining to Resident A ingesting the wrong medications on 5/11/19. According to the incident report at 10:00 am on 5/11/19, "dining room Bradford Resident sitting at table with 3 other residents. [Resident A] was given the cup of pills prepared for [Resident B] by Sheri Emery. Sleepy, ↓[decreased] BP [blood pressure] + ↓ P [pulse] B/P recorded q. [every] 15 minutes x 1º [one hour] then q 1º x 12º Liquids, encouraged, resident drank 8 oz coffee, 16 oz water + juice 8 oz orange juice 5/11/19 3:00 pm sent to PPN [Providence Park Novi hospital]". The report indicates "Dr. Kathleen Step NP" was notified on 5/11/19 at 10:15 am, however, Kathleen Step is a nurse practitioner not Resident A's physician as the title "Dr." would indicate. The incident report also indicates Resident A's "Responsible Party" was notified on 5/11/19 at 10:15 am. For corrective measures to prevent recurrence, it is written, "re-education on medication administration process." Additional documentation on the bottom of the incident report, "Addendum to 'care provided' – J. LeBlanc LPN notified K. Step N. P. of error BP + P monitored q. 5 mins x 1 hour – fluids pushed. Res. Remained awake, oriented Ṫ + verbal. BP remained WNLs [within normal limits] – pulse remained low. J. LeBlanc LPN contacted Dr. Step NP and POA/[Resident A's authorized representative 5/11/19 at 2:15 pm – re: transport to hosp. for eval + tx [treatment] of ↓ pulse. All agreed – EMS called at 2:30 pm and resident transported to Providence Park Novi. 5-13-19 Resident remains at Providence Park Novi in improved condition. Family will be keeping us up to date."

On 6/21/19, I interviewed facility nurse Jude LeBlanc by telephone. Ms. LeBlanc said she was on another unit passing medications when the facility's administrator texted her to come to the Bradford Unit. Ms. LeBlanc said she believed Sheri Emery gave the medications to Resident A, and Ms. LeBlanc notified the nurse practitioner Kathleen Step. Ms. LeBlanc said she is "guessing" that she notified Ms. Step at 9:45 am. Ms. LeBlanc said Ms. Step told her to monitor Resident A's vital signs and if the blood pressure did not come up, to send her to the emergency room. Ms. LeBlanc said she thought someone left the medications on the dining room table.

On 6/21/19, I interviewed the licensee's authorized representative Sheri Emery at the facility. Ms. Emery said Resident A is a 93-year old female with a diagnosis of dementia. Ms. Emery said the morning of 5/11/19, the facility was short staffed. Ms. Emery told staff Ivory Brown that she would take over passing medications from her and Ms. Brown could tend to the residents. Ms. Emery said she observed from across the room that Resident A and Resident B were seated at the dining room table. Each resident had a cup of pills in front of them. Ms. Emery said Ms. Brown had put them there. Ms. Emery said she picked up both cups of medications and put them in the medication cart until she could determine which cup belonged to which resident. Ms.

Emery said Ms. Brown came to the cart and informed Ms. Emery which cup of meds belonged to which resident. Ms. Emery said she gave to Resident A the cup of meds that Ms. Emery understood belonged to her. Ms. Emery said she was then in a room with another resident when Ms. Brown came in and reportedly said, "You gave the meds to the wrong resident." I asked Ms. Emery where Resident A's medications were, and she said they were still in the medication cart. Ms. Emery said she knew not to just leave them on the table. Ms. Emery said she handed the medication cup to Resident A and watched her swallow them. Ms. Emery said the facility nurse Jude LeBlanc called the resident's nurse practitioner (NP) Kathleen Step, who was working on-call for the resident's physician. Ms. Emery called said she notified Resident A's family and that the incident "must have happened at 10 am. That's what I wrote. Breakfast is between 8 and 10 am". Ms. Emery said Resident A did not receive her own prescribed medications, she only received Resident B's medications. Ms. Emery said per Ms. Step's instructions, we started taking Resident A's blood pressure every half an hour. Ms. Emery provided documentation of the blood pressure and pulse readings. A *Progress Note* was written with some times crossed out and changed as follows:

"[Resident A] – Push fluids
Blood Pressure

Q 15 min @	10:20 A		119/53 – 41	
	10:35A		88/32 – 54	113/42
	10:50A	@10:35	102/51 - 45	
	~~11:10A~~	10:45	98/80 – 81	102/43
Then q 1º	12 N	10:50	95/39 – 74	
	~~1 P~~	10:55	90/33 – 76	
	~~2P~~	11:05	134/74 – 70	70/43 – 47
	12P	11:10	95/49 – 59	
	1 P		95/43	Lo retake 117/40
	2 P		117/49	40"

On 6/21/19, I interviewed facility staff Ivory Brown at the facility. Ms. Brown said the incident occurred during breakfast about 8:30 – 9 am. Ms. Brown said she has four female residents in the Bradford Unit of the facility, that sit together at the same dining room table and "they can take their own medications independently". Ms. Brown affirmed that all four of these individuals have diagnosis of dementia. Ms. Brown said she had put the various medications into cups for Resident A, Resident B, and Resident C, and put the cups on the dining room table in front of them, as she usually does. Ms. Brown said she also does this for Resident D, but Resident D was not yet in the dining room. Ms. Brown said she returned to the medication cart from where she could observe the three residents consume their medications. Ms. Brown said she enters her initials into the electronic medication administration record (MAR) after the residents take their medications. Ms. Brown said she was trained by facility nurse Doris Ann Henry to administer medications this way.

Ms. Brown said the facility was short staffed on 5/11/19, so Ms. Emery came into the Bradford Unit and offered to administer medications while Ms. Brown gets the other residents up for breakfast. Ms. Brown said she left the dining room to assist Resident D. Ms. Brown said Ms. Emery then came to Resident D's room and said Resident A and Resident B were arguing over their medications. Ms. Brown said she came out of the resident's room and informed Ms. Emery which cup of pills belonged to which resident. Ms. Brown said she later walked into the dining area and noticed Resident A's cup of pills was on the table in front of Resident B, and an empty cup was in front of Resident A. Ms. Brown said she ran to Ms. Emery, who was administering medications to Resident D in her bathroom. Ms. Brown asked Ms. Emery about Resident B having Resident A's medications in front of her and Ms. Emery reportedly said, "What do you mean?" Ms. Brown stated, "I said to her, 'I think you got them messed up'. She said, 'You're not supposed to leave.' I said, 'You were in charge'. There was a tiny argument, so I went to Jude [LeBlanc] but I think Jude already knew. Sherry already told her."

On 6/21/19. I reviewed staff training documentation at the facility, and confirmed that Ms. Emery, Ms. Brown and Ms. Henry completed training in medication administration. Ms. Henry did train Ms. Brown.

Ms. Emery also provided additional documentation about the medication error incident. It included a typed note reportedly from staff Donyel Snead. It is dated 5/12/19 and reads, "On May 11, 2019 I enter the Bradford unit at 8:15 am and Ivory Brown was passing out medication to the residence (sic). At approximately 9:00am Sheri Emery took over the med passing duties. Fifteen minutes later [Resident B] handed me her cup of medication and said, "This isn't mine. I don't take this much medication". When I walked over to the table, I observed [Resident D] sitting in her normal seat with an empty cup. I also saw [Resident A's] cup of pills sitting on the right side of her placemat. I handed [Resident B's] cup of pills to Sheri and I did not observe what she did with them. One hour later I observed [Resident A] moving in a non-characteristic manner and unable to speak clearly. Donyel Snead"

On 6/21/19, I interviewed Life Enrichment staff Donyel Snead by telephone. Ms. Snead affirmed she had typed and submitted the above document as written. Ms. Snead said she observed Ivory Brown put the medication cups on the table in front of the residents, as she often does for Residents A, B, C and D. Ms. Snead said some other staff do this too, but she could not recall specific names. Ms. Snead said no one was watching the residents, then Ms. Emery came into the room to work. Ms. Snead said Ms. Emery became confused when she saw the cups on the table, and she was listening to Resident B. Ms. Snead said she "laughed it off" and "wasn't taking [Resident B] seriously", because she knew they were Resident B's pills. Ms. Snead said Ms. Emery was passing medications to other residents when Resident B came to her with the cup of pills. Ms. Snead said she handed them to Ms. Emery.

On 6/21/19, I interviewed facility nurse Doris Ann Henry by telephone. Ms. Henry denies having trained anyone to set up medications in cups and put the cups in front

of the residents to consume independently. Ms. Henry said staff are trained to administer only one resident's medication at a time. Staff are to stay right with the resident and ensure the medication is swallowed and then document in the MAR that the medication was administered.

On 6/21/19, I reviewed Resident B's MAR that included all the medications prescribed for her 9 am administration. In addition to all the medications notated by the complainant, the cup that Resident A received would have also included Resident B's medication anastrozole 1 mg. prescribed for administration at 9:00 am.

On 6/21/19, I interviewed Resident A at the facility. Resident A did not remember the medication error that sent her to the hospital. Resident A did affirm that staff used to put her medication into a cup and set it on the dining room table but said they do not do that anymore. Resident A now receives hospice services since she returned from the hospital on 5/21/19.

On 6/24/19, I interviewed Susan Swaffar, the office staff to nurse practitioner Kathleen Step. Ms. Swaffar said NP Kathleen Step was not on-call on 5/11/19, Dr. Muhammed Elbashir was on-call. One call was received from the Addington Place facility but it was a hang-up call with no message. Ms. Swaffar did not know the time of the call. Ms. Swaffar said the staff may have called Ms. Step's personal cell phone but given that Ms. Step was not on-call that day, she probably would not have answered. Ms. Swaffar said she would check with Ms. Step and let me know.

On 6/24/19, in a follow up telephone interview, Ms. LeBlanc said she did not know what time the incident occurred because she was on another unit. Ms. LeBlanc then checked her cell phone text messages and said that Ms. Emery texted her at 9:39 am that she was needed in the Bradford unit. There had been a medication error. Ms. LeBlanc also checked her phone and said she called Ms. Step on her personal cell phone at 10:15 am and was instructed to push Resident A's fluids, take her blood pressure and pulse readings every 15 minutes and if the vital signs did not come up, then send Resident A to the hospital. Ms. LeBlanc said Ms. Step was not clear on the time period nor the readings that would indicate the need to send her out, but Ms. LeBlanc believed Ms. Step was leaving it up to her to determine. Ms. LeBlanc said the blood pressure and pulse readings were "very low and making me nervous" but that Resident A was always alert and verbal. Ms. LeBlanc said she was "hopeful" but at 2:00 pm when her shift would be ending and she would be leaving the facility soon, she decided it was time to send Resident A to the hospital. In regard to leaving medications in cups on the table for residents, Ms. LeBlanc said she reminds staff that this is not an acceptable practice.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(1) Medication shall be given, taken, or applied pursuant to labeling instructions or orders by the prescribing licensed health care professional.
ANALYSIS:	Although the staff recall differing sequences of events and times, it is confirmed that Resident A ingested another resident's medications, either by staff leaving cups of pills on the dining room table or by Ms. Emery handing Resident B's cup of pills that was pre-set by Ms. Brown to Resident A. The medication was not given pursuant to labeling instructions.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A obtained the medications because they were left unattended by staff.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(5) A home shall take reasonable precautions to ensure or assure that prescription medication is not used by a person other than the resident for whom the medication is prescribed.
ANALYSIS:	Ivory Brown said she put medications into cups and set them on one table for three residents to take "independently", all residents of whom have a diagnosis of dementia. Ms. Emery and Ms. Snead affirmed having observed the cups of medications on the dining room table where residents were seated. While it is uncertain whether Resident A took the medications from the cup independently or from Ms. Emery, it is certain that pre-setting the medications and setting the cups on the table resulted in confusion and consequently, the medication error of Resident A ingesting Resident B's medications. Therefore, the home did not take reasonable precautions to ensure the prescription medication was not used by a person other than for whom it was prescribed.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

According to the complainant and Ms. Emery, Resident A did not receive her own prescribed medications the morning of 5/11/19. However, reviewing Resident A's electronic MAR revealed Ivory Brown's initials had been entered for all of Resident A's 9 am medications indicating they had been administered to Resident A. Resident A's prescribed medications were as follows:

Amlodipine besylate 2.5 mg
Amlodipine besylate 5 mg
Aspirin 81 mg
Coenzyme Q10
Famotidine 20 mg
Folic Acid 800 mcg
Meclizine 12.5 mg
Polyeth Gly Pow 3350 (Miralax) 17 grams with 8 ounces of beverage
Presevision Cap Areds 2
Senna 8.6 mg

Ms. Brown said "It's possible that I signed [the electronic MAR system] before [Resident A] took her meds. Or it's possible that I didn't sign off [the electronic MAR system] and Sherry would automatically enter my initials." Ms. Brown said she did not observe Resident A take her medications on 5/11/19, so she does not believe she entered her initials into the electronic system. Ms. Brown said she may have forgotten to log out of the computer system when Ms. Emery took over the med pass and consequently, Ms. Emery would have entered Ms. Brown's initials into the MAR for Resident A. If that was the case, Ms. Brown affirmed that Ms. Emery may have inappropriately entered Ms. Brown's initials for all of the medications of all the residents that Ms. Emery administered that day.

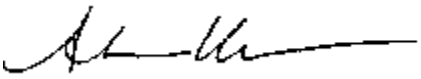
APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(3) If a home or the home's administrator or direct care staff member supervises the taking of medication by a resident, then the home shall comply with all of the following provisions: **(b) Complete an individual medication log that contains all of the following information:** **(v) The initials of the person who administered the medication, which shall be entered at the time the medication is given.**

ANALYSIS:	Ivory Brown's initials were entered into the electronic MAR system by either Ms. Brown or Sheri Emery on 5/11/19 for Resident A's 9:00 am prescribed medications. Ms. Brown's initials would indicate Resident A received her medications as prescribed. However, according to the complainant, Ms. Brown and Ms. Emery, Resident A did not receive her own medications as prescribed that morning. Ms. Brown's initials were not entered into the electronic MAR system in accordance with this rule and consequently, do not accurately reflect the medications Resident A did and did not receive on 5/11/19.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 6/27/19, I reviewed the findings of this report with the licensee authorized representative Sheri Emery by telephone. Ms. Emery had no questions and said she already knows what corrective measures she is putting into place.

IV. RECOMMENDATION

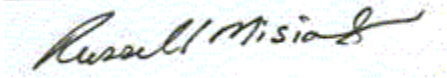
Contingent upon receipt of an acceptable corrective action plan, it is recommended that the status of the license remain unchanged.



6/27/19

Andrea Krausmann — Date
Licensing Staff

Approved By:



6/27/19

Russell B. Misiak — Date
Area Manager