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

July 3, 2019

RE: License #: AH820378951
Investigation #: 2019A1023013
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.

The corrective action plan by 7/24/19. 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 (616) 356-0183.Your missing a paragraph here.

Sincerely,

Shawne Cripps

Shawne Cripps, Licensing Staff
Bureau of Community and Health Systems
350 Ottawa, N.W. Unit 13, 7th Floor
Grand Rapids, MI 49503
313-296-5692
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH820378951
Investigation #:	2019A1023013
Complaint Receipt Date:	06/05/2019
Investigation Initiation Date:	06/05/2019
Report Due Date:	08/04/2019
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/Auth Rep:	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?
There is not enough staff available to provide basic care to residents.	Yes
Resident service plans are not followed resulting in showers not provided, leg edema, and skin problems.	Yes
Additional Findings	No

III. METHODOLOGY

06/05/2019	Special Investigation Intake 2019A1023013
06/05/2019	Special Investigation Initiated - On Site
06/05/2019	Inspection Completed-BCAL Sub. Compliance
07/03/2019	Exit Conference
07/03/2019	Special Investigation report sent to facility
07/03/2019	Special Investigation report sent to complainant

ALLEGATION:

There is not enough staff available to provide basic care to residents.

INVESTIGATION:

On 6/5/19, I interviewed the complainant. The complainant reported that visitors had to serve food to the residents and assist residents with the meal yesterday. The complainant reported staffing shortages were problematic for approximately two weeks and culminated on 6/4/19 when there was one staff person responsible to care for 18 residents on one of the four neighborhoods.

On 6/5/19, I interviewed Ms. Emery at the facility. Ms. Emery reported that on 6/4/19, multiple staff members scheduled to work did not report to work and several

other staff members arrived “late”. She stated the combination of staff not showing up or showing up late affected residents in all four neighborhoods.

Ms. Emery provided for my review the *Daily Neighborhood Assignment* sheets for 6/4/19. The 7 am to 3 pm shift noted the following:

> Asbury Neighborhood: Four staff members were scheduled. One did not show-up for work and two were “late”. There was one orientee “shadowing” a full-time employee.
> Bradford Neighborhood: Four staff members were scheduled. One did not show-up for work and one staff member left at 7:30 am. The other two staff members were “late”. The Supervisor assigned for the shift was reassigned to the unit to pass medications.
> Carrington Neighborhood: Two staff members worked as well as one orientee.
> Devonshire Neighborhood: Two staff members worked.

The 3 pm to 11 pm shift noted the following:

> Asbury Neighborhood: The Supervisor from the dayshift was assigned to work the afternoon shift to pass meds. One staff member was scheduled to work with a new employee.
> Bradford Neighborhood: Three employees were scheduled to work. One employee worked the entire shift and one employee worked from 5:00 pm to 9:00 pm. One employee did not show-up for work.
> Carrington Neighborhood: Two employees were scheduled to work and two employees worked.
> Devonshire Neighborhood: One employee was scheduled to work and train another person for medications. A second employee (from the kitchen) worked this unit and the administrator (Ashley) worked the floor.

At the bottom of this document, four employees were listed as “WNBI” (Will not be in); one person was listed as “Quit” and two employees were listed as “haven’t heard anything”.

On 6/5/19, I observed the noontime meal in Resident A’s neighborhood dining room. There were 18 residents living on this unit. There were four staff members working on the neighborhood. Four residents were being fed by the four staff members.

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:	The complainant alleges that the facility was understaffed on 6/4. Interview with Ms. Emery and review of the staffing sheets reveals there was not sufficient staff members to provide care to residents on 6/4/19.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident service plans are not followed resulting in showers not provided, leg edema and skin problems.

INVESTIGATION:

The complainant reported Resident A did not receive a bath and her stockings were not properly applied resulting in significant swelling in specific areas of the lower extremity.

Resident A and B's service plans directed staff members to provide showers to each resident twice a week.

I reviewed Resident A and B's bath sheets that staff documented for the last 30 days the specific dates when the residents had received their showers. Resident A received a shower on 5/24, 5/28, and 5/31/19. Resident B received a shower on 5/22. The facility was unable to provide evidence that both Resident A and B received two showers a week.

Resident A's plan directed staff members to don Resident A's stockings and wrap legs daily to minimize lower extremity edema.

I observed Resident A's legs and found the stockings were donned properly and the legs were wrapped with elastic wraps as identified in the Service Plan. The complainant pointed out an area of significant swelling located above and around the left ankle, stating this swelling was a result of the stockings not being donned properly and leg wraps not being wrapped properly. There were no skin tears or weeping skin noted. Interventions included on the service plan were compression boots, leg stockings and wraps, and elevate legs as much as possible. There was

no evidence Resident A's leg swelling was reported to the physician and no instructions regarding staff members responsibility to notify the physician regarding swelling.

APPLICABLE RULE	
R 325.1933	**Personal care of residents.**
	A home shall provide a resident necessary assistance with personal care such as, but not limited to, care of the skin, mouth and teeth, hands and feet, and the shampooing and grooming of the hair as specified in the resident's service plan.
ANALYSIS:	Based on review of the bathing sheets and service plans for Resident A and B, the facility was not able to demonstrate residents were given baths/showers twice a week as documented in the service plan. Based on review of Resident A's service plan, there was no instruction regarding when to contact the physician regarding care of edema.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 7/03/19 I shared the findings of this report with licensee authorized epresentative Sheri Emery who was in agreement with the findings.

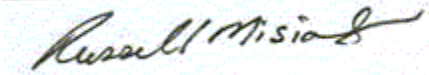
IV. RECOMMENDATION

I recommend the status of the license remain unchanged.

6/21/19

Shawne Cripps Date
Licensing Staff

Approved By:



6/25/19

Russell B. Misiak Date
Area Manager