GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 7, 2021

Nathan Boyle
ARHC ARCLRMI01 TRS, LLC
106 York Road
Jenkintown, PA 19046

RE: License #: AL630365576
Investigation #: 2021A0605044
Addington Place of Clarkston 2

Dear Mr. Boyle:

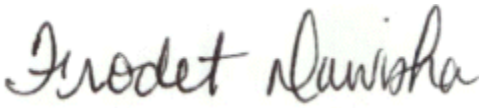
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



Frodet Dawisha, Licensing Consultant
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(248) 303-6348

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL630365576
Investigation #:	2021A0605044
Complaint Receipt Date:	08/03/2021
Investigation Initiation Date:	08/04/2021
Report Due Date:	10/02/2021
Licensee Name:	ARHC ARCLRMI01 TRS, LLC
Licensee Address:	106 York Road Jenkintown, PA 19046
Licensee Telephone #:	(215) 887-2582
Administrator/Licensee Designee:	Nathan Boyle
Name of Facility:	Addington Place of Clarkston 2
Facility Address:	5800 Water Tower Pl Clarkston, MI 48346
Facility Telephone #:	(248) 625-0500
Original Issuance Date:	06/19/2015
License Status:	REGULAR
Effective Date:	01/22/2021
Expiration Date:	01/21/2023
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED MENTALLY ILL ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
There is insufficient staff on duty to provide proper care to 11 residents. Since 07/17/2021, Resident A had four major falls requiring her to go to the hospital. Resident A had massive bruising due to the different falls. Resident A had a pubic bone fracture due to one of the falls.	Yes
Resident A had foot pain on 7/22/2021, and it was discovered that Resident A's toes were encrusted and there was a substance in between toes. Resident A had not been seen by a podiatrist for a long time.	No

III. METHODOLOGY

08/03/2021	Special Investigation Intake 2021A0605044
08/04/2021	Special Investigation Initiated - Telephone I contacted the reporting person (RP) regarding the allegations.
08/05/2021	Contact - Face to Face I made a face-to-face contact with the RP to retrieve documents pertaining to Resident A.
08/05/2021	Inspection Completed On-site I conducted an unannounced on-site investigation and interviewed Resident A, direct care staff (DCS) Sarah Cole and Debby Oaks. I also interviewed the executive director Tyler May, the Director of Wellness Lucy Noble, and the Resident Care Manager Jasmine Croteau. I reviewed Resident A's records.
09/02/2021	Contact - Telephone call made I interviewed Resident B's, C's, and D's DPOA's, DCS Melody Itter, Dominque Jackson-Albring and Verona Johnson regarding the allegations.
09/16/2021	Exit Conference I conducted the exit conference with licensee Nathan Boyle regarding my findings.

ALLEGATION:

There is insufficient staff on duty to provide proper care to 11 residents. Since 07/17/2021, Resident A had four major falls requiring her to go to the hospital. Resident A had massive bruising due to the different falls. Resident A had a pubic bone fracture due to one of the falls.

INVESTIGATION:

On 08/04/2021, intake #181132 was assigned for investigation regarding insufficient staff on duty resulting in Resident A having four major falls resulting in hospitalization and injuries.

On 08/04/2021, I contacted the reporting person (RP) via telephone regarding the allegations. The RP stated that Resident A had fallen on four different occasions all after 07/17/2021, with the most recent fall resulted in Resident A getting staples in her head. Resident A is legally blind in both eyes. The RP last saw Resident A on 08/02/2021 in a wheelchair that did not belong to Resident A at this facility. The RP is concerned that due to a shortage in staff at this facility, staff are not supervising Resident A; therefore, Resident A is attempting to get up on her own and falling. The RP was unable to get staff to provide RP with information as to how Resident A fell or how Resident A sustained any of her injuries, fractured pubic and staples in her head. The RP reported that Resident A fell first fell on 07/17/2021, and no explanation was given. Resident A was taken to the hospital and then discharged home. The second fall was on 07/23/2021 which staff told RP that the fall was not witnessed, but that staff "think Resident A slipped off the couch, tried to stand up and fell lading on her bottom. Resident A was not taken to the hospital. The third fall was on 07/27/2021, staff "think she fell in the common area and hit the side of her head. Resident A was taken to the hospital where it was determined she had a fractured pubic bone that occurred on the previous fall, 07/23/2021. The most recent fall was on 07/30/2021 when Resident A fell and hit her head resulting in three staples on the top of her head. The RP was advised by staff that again this fall was not witnessed and that "Resident A fell somewhere and hit the back of her head." The RP expressed concerns about Resident A's care at this facility.

On 08/05/2021, I conducted a face-to-face with the RP who had additional information regarding Resident A. The RP stated that Resident A was supposedly seen by the podiatrist on 06/23/2021, but this facility did not provide the RP with any documentation to reflect that. Resident A's toes were observed by a family member to be encrusted between the toes with a thick substance. The RP advised a copy of Resident A's assessment plan was never signed nor provided to them. In addition, Resident A's resident care agreement was never signed by RP, nor a copy provided to them.

On 08/05/2021, I conducted an unannounced on-site investigation. I observed Resident A but attempted to interview Resident A and was unsuccessful due to Resident A's

cognitive disability. Resident A was sitting in the wheelchair with the Activity Director Michelle. I interviewed DCS Sarah Cole, Debbie Oaks, the Resident Care Manager Jasmine Croteau, Director of Wellness Lucy Noble and Executive Director Tyler May. I also reviewed Resident A's assessment plan, resident care agreement and health care appraisals. I received a copy of the staff schedule and a copy of Resident A's progress note from the podiatrist dated 06/23/2021.

On 08/05/2021, DCS Sarah Cole was interviewed regarding the allegations. Ms. Cole has been working for this corporation for 10 years. She works once a week from 6:30AM-2:30PM. Ms. Cole stated if fully staffed, there is always two staff per shift, but recently this facility has been short staffed; therefore, there have been only one staff during the afternoon and midnight shifts. Ms. Cole stated she hears from other staff saying this facility is short staffed and that staff are not able to do everything for all the residents when there is only one staff on duty. Ms. Cole stated Resident A is a one person assist; however, Resident B and Resident C are both a two person assist if a staff does not know how to use the Hoyer lift. Ms. Cole stated that Resident A has been in a wheelchair for a while and currently there is an alarm on her wheelchair to alert staff when Resident A tries to get out of the wheelchair. Resident A has been declining and gets agitated during the afternoon, which is when Resident A has been falling. Ms. Cole stated when a fall occurs, the staff on duty completes an incident report (IR), calls the Director of Wellness, Lucy Noble and forwards the IR to Ms. Noble who then calls the family and then forwards the IR to all the party's involved including to licensing. Ms. Cole stated she has never witnessed Resident A fall but "feels like the falls are in the afternoon and the midnight shift." Ms. Cole stated that Resident A has been a full assist for about three weeks now. Resident A requires assistance getting out of bed, dressing, and toileting. Ms. Cole stated the family refused to have alarms placed on Resident A's wheelchair or bed to alert staff if/when Resident A tried to get up. However, Ms. Cole reported that staff put a tab alarm on Resident A whenever she is in a wheelchair to alert staff because Resident A continues to try to get up without assistance. Ms. Cole stated she read on the staff tablet that last week Resident A fell and required staples on her head. Ms. Cole does not know where or how Resident A fell, but that she had fallen prior, once in the living room and once in Resident A's bedroom.

Ms. Cole stated Resident A's family brought to her attention (unknown date) the crust between Resident A's toes. The family told Ms. Cole that Resident A should have been seen by a podiatrist since the family thought the podiatrist visits monthly. Ms. Cole advised the family she did not have any information to provide about Resident A's toes and when the podiatrist was supposed to visit with Resident A.

On 08/05/2021, I interviewed DCS Debby Oaks regarding the allegations. Ms. Oaks has been with this corporation for three years. She works the first shift, 6:30AM-2:30PM. Ms. Oaks stated there is two DCS on shift, but not always. Ms. Oaks reported that sometimes during the afternoon and midnight shifts there is only one DCS on shift. Ms. Oaks reported that Resident B and Resident C are a two person assist if DCS do not know how to utilize the Hoyer lift. Ms. Oaks stated when Resident A moved into Addington Place, she was violent and aggressive, yelling and screaming. Resident A

was put on medication which did not work. However, her medication was changed around two-three months ago and they began working as Resident A was calm, but then Resident A was not walking, her gait was unsteady, and she was unable to dress herself. The staff contacted the on-call nurse about a month ago to examine Resident A and it was determined to take her off her medication. It was determined it was not the medication, but that Ms. Oaks was declining in her health. She stated after the decline, Ms. Oaks began falling.

Ms. Oaks stated although Resident A has been falling, it has never been during first shift when Ms. Oaks is working. Ms. Oaks heard and read on the staff log that Resident A's falls are mostly during the afternoon and midnight shifts. Ms. Oaks stated when a resident falls, DCS call the Director of Wellness Lucy Noble who is a registered nurse. Ms. Noble comes out to the facility and assesses the resident to determine if further action is needed, i.e., hospitalization. Ms. Oaks will then complete the IR and submit the IR to Ms. Noble who then sends it to all required parties. Ms. Oaks stated she read on the staff log on the tablet that on second (afternoon) shift on 07/30/2021 around 5:30PM, Resident A fell and was sent out to the hospital for staples on her head. I reviewed the staff log that stated the fall took place in the dining room as Resident A got up off the wheelchair became agitated and tripped over the wheelchair trying to get around it. Ms. Oaks does not believe there is a script for the wheelchair, but stated the facility began using the wheelchair after one of the falls in 07/2021. Ms. Oaks stated she has no other information about the falls since they never occurred during her shift. Ms. Oaks reported she did not review Resident A's assessment plan as it was not available for review as all the assessment plans are located at their other building. Ms. Oaks stated that all DCS follow the tasks that are put on the tablet daily by the director of wellness. The tasks are what DCS need to do for each resident for that specific date.

On 08/05/2021, I interviewed the Resident Care Manager Jasmine Croteau, Director of Wellness, registered nurse Lucy Noble and Executive Director Tyler May regarding the allegations. Ms. Croteau, Ms. Noble and Mr. May are new to their positions but were able to provide information pertaining to the allegations. Ms. Croteau reported that Resident A's decline began about six months ago. Resident A required more assistance and was unable to tie her own shoes or dress herself. Ms. Croteau stated a month ago, Resident A's gait became unsteady so the primary physician suspended her medications believing it may be due to her Risperidone and Depakote. However, Resident A's gait was still unsteady, so it was determined it was not the medication, but that Resident A's health was declining. Ms. Croteau stated that Resident A tries to get up on her own and that is when her falls occur. She stated there is two staff per shift; however, sometimes when a staff calls in or does not show up, then there is a floater staff that goes back and forth from building to building. Ms. Croteau stated the falls are occurring during the afternoon and midnight shifts. Ms. Noble stated currently the facility has implemented a pad alarm on the wheelchair for Resident A and that Resident A is monitored and checked on every two hours.

Ms. Croteau stated the podiatrist visits residents every two-three month and Resident A was last seen on 06/23/2021. According to the visit from the podiatrist, Resident A did

not need to be seen for another two-three month and Ms. Noble stated the podiatrist will be visiting on 08/12/2021 to see all the residents.

I requested to review Resident A's assessment plan, health care appraisal and resident care agreement and the staff schedule. Resident A's last assessment plan was completed on 05/15/2020 and it was incomplete and not signed by Resident A's designated representative. Resident A's last resident care agreement was completed on 03/19/2020 and it was not signed by Resident A's designated representative. Resident A's last health care appraisal was completed on 05/15/2020 and it stated that Resident A was "fully ambulatory." In addition, the use of a wheelchair was not in Resident A's assessment plan. I also received a copy of the staff schedule. According to the staff schedule, there was only one DCS on shift on 07/17/2021 during the midnight shift (10:30PM-6:30AM), one DCS on shift on 07/18/2021 during morning (6:30AM-2:30PM) and afternoon shifts (2:30PM-10:30PM), one DCS on shift on 07/19/2021 during morning (6:30AM-2:30PM), afternoon (2:30PM-10:30PM) and midnight shift (10:30PM-6:30AM) and one DCS on shift on 07/21/2021 during the afternoon shift (2:30PM-10:30PM). There were no incident reports submitted by this facility for any of Resident A's falls that resulted in hospitalizations.

On 09/02/2021, I interviewed Resident B's durable power of attorney (DPOA 1) via telephone. The DPOA 1 stated Resident B used to use a cane and a walker at the facility. Per the physical therapist (PT) that was working with Resident B at the time, the recommendation was for Resident B to walk around the facility using a walker, but due to a staff shortage, Resident B was not encouraged to walk; therefore, he lost his mobility and was put in a wheelchair. The DPOA 1 stated this occurred a couple of years ago and since then, Resident B is now a two-person assist. Another concern the DPOA 1 had was that Resident B is hard of hearing and wears hearing aids; however, Resident B does not want to wear them and when he does, he pulls them out. The DPOA 1 has replaced Resident B's hearing aids three times because staff either lost the hearing aids or washed them. The DPOA 1 stated this too has been a battle for about two years. The DPOA 1 stated due to not enough staff on shift always, Resident B is not safe. The DPOA 1 has visited the facility late morning and found Resident B still sleeping in bed. The staff told the DPOA 1 that Resident B is "up all night," so they allow him to sleep until 11AM-12PM. The DPOA 1 does not know if Resident B is receiving the care, he requires due to lack of staff and staff turnaround as new staff do not know the residents' needs.

On 09/02/2021, I interviewed Resident C's DPOA 2 via telephone. The DPOA 2 stated that Resident C has been at this facility for over eight years. The DPOA 2 is unable to say if Resident C is getting the proper care as the DPOA 2 visits infrequently. However, the DPOA 2 stated that there has been a complete turnover in staff and where she used to have complete confidence in Resident C receiving proper care, now the DPOA 2 does not. Resident C is now a two-person assist and requires a Hoyer lift. The DPOA 2 stated whenever a visit was conducted, there were always two DCS on shift; however, since the visits are infrequent, they cannot state if there is always two DCS on shift. The

DPOA 2 stated the facility was not clean in the past but when they visited a week ago, it was clean and Resident C was in good spirits.

On 09/02/2021, I interviewed Resident D's DPOA 3 via telephone. The DPOA 3 stated they visit about two-three times per week. Resident D seems happy at the facility and seems to be cared for properly. Resident D has told the DPOA 3 that staff is "really nice," to her. The DPOA 3 stated there was only one time where there was only one DCS on shift when she visited Resident D. The DPOA 3 does not recall the date.

On 09/02/2021, I interviewed DCS Melody Itter via telephone regarding the allegations. Ms. Itter has been with the corporation for one year and works the midnight shift, 10:30PM-6:30AM. Ms. Itter stated there is always two DCS per shift, but there was a time last month when she worked alone because the DCS did not show up. Ms. Itter stated it is difficult for management to find coverage for the midnight shift. Ms. Itter reported Resident B and Resident C are a two-person assist. She reported that Resident B becomes combative during her shift, so Resident B is stays up late to calm down; therefore, sleeps in during the morning. Ms. Itter stated she was aware that Resident A had fallen several times and the most recent fall resulted in Resident A receiving staples. Ms. Itter stated the fall did not occur during her shift. Ms. Itter reported that Resident A has unsteady gait and tries to get up on her own without staff knowledge and this is when she falls. Ms. Itter stated that there is an alarm now placed on Resident A's bed to alert staff when Resident A is trying to get up so staff can get to Resident A quickly before she falls. Ms. Itter stated that Resident A has gotten up during the midnight shift without her knowledge trying to go to the bathroom, but now with the bed alarm Ms. Itter can assist Resident A to the bathroom and back into bed safely.

Ms. Itter stated she does not know anything about the crust between Resident A's toes and is unsure if a podiatrist has seen Resident A. Ms. Itter stated she has access to the assessment plans, but that they are not placed in a consistent place for staff to locate. She stated that staff follow the task tablet for residents' needs. Ms. Itter stated her only concern about this facility is the staff shortage especially when a staff does not show up for their shift.

On 09/02/2021, I interviewed DCS Dominque Jackson-Albring via telephone regarding the allegations. Ms. Jackson-Albring stated she began with this corporation on 05/03/2021 and works both morning and afternoon shifts. She stated that Resident A has not fallen during her shifts but that she has only worked with Resident A once. When she worked with Resident A, she assisted Resident A out of her wheelchair and onto the toilet without incident. Ms. Jackson-Albring stated that her only concern is the staff shortage. She stated when a DCS does not show up, the Resident Care Manager Jamsine Croteau has worked the shift to ensure there is coverage. Ms. Jackson-Albring stated she has no other concerns or information to provide regarding Resident A's falls or concerns with Resident A's toes.

On 09/02/2021, I interviewed DCS Verona Johnson via telephone regarding the allegations. Ms. Johnson stated she quit last month because there was not enough staff

on the afternoon shifts when she worked. Ms. Johnson reported that she worked with Resident A but cannot recall if Resident A has fallen on her shift. Ms. Johnson recalls Resident A returning from the hospital with staples in her head, but she had no idea what happened. Ms. Johnson stated she has no additional information to offer about the falls or about Resident A's toes.

On 09/16/2021, I conducted the exit conference with licensee designee Nathan Boyle via telephone with my findings. Mr. Boyle advised that he has and will continue to work closely with the Executive Director Tyler May and the Director of Wellness Lucy Boyle regarding the concerns. Mr. Boyle agreed to submit a corrective action plan.

APPLICABLE RULE	
R 400.15206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	Based on my investigation and information gathered, there is insufficient DCS on duty at all times to provide for the supervision, personal care, and protection of the residents. According to several DCS that were interviewed, Resident B and Resident C are a two-person assist. I reviewed the staff schedule, there was only one DCS on shift on 07/17/2021 during the midnight shift (10:30PM-6:30AM), one DCS on shift on 07/18/2021 during morning (6:30AM-2:30PM) and afternoon shifts (2:30PM-10:30PM), one DCS on shift on 07/19/2021 during morning (6:30AM-2:30PM), afternoon (2:30PM-10:30PM) and midnight shift (10:30PM-6:30AM) and one DCS on shift on 07/21/2021 during the afternoon shift (2:30PM-10:30PM).
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(10) At the time of the resident's admission to the home, a licensee shall require that the resident or the resident's designated representative provide a written health care appraisal that is completed within the 90-day period before the resident's admission to the home. A written health care appraisal shall be completed at least annually. If a written

	health care appraisal is not available at the time of an emergency admission, a licensee shall require that the appraisal be obtained not later than 30 days after admission. A department health care appraisal form shall be used unless prior authorization for a substitute form has been granted, in writing, by the department.
ANALYSIS:	Based on my investigation and the information gathered, Resident A did not have an annual assessment plan completed in 05/2021 as the most recent health care appraisal I reviewed at this facility was completed on 05/15/2020.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	Based on my investigation and information gathered, Resident A's assessment plan was not completed annually. The assessment plan available for my review expired on 05/15/2020 and was incomplete.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(8) A copy of the signed resident care agreement shall be provided to the resident or the resident's designated representative. A copy of the resident care agreement shall be maintained in the resident's record.

ANALYSIS:	Based on my investigation and information gathered, a copy of Resident A's resident care agreement was not completed annually. I reviewed the resident care agreement completed on 03/19/2020 which was not signed by Resident A's designated representative.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(9) A licensee shall review the written resident care agreement with the resident or the resident's designated representative and responsible agency, if applicable, at least annually or more often if necessary.
ANALYSIS:	Based on my investigation and information gathered, a copy of the resident care agreement was not provided to the designated representative, only reviewed via telephone as handwritten on the form.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Based on my investigation and information gathered, Resident A's protection and safety was not attended to at all times. Resident A's health declined, unsteady gait and inability to walk which confined her to a wheelchair. Resident A required additional supervision as Resident A tried to get up on her own which caused her to fall four different times. According to the staff interviewed, all four falls were unwitnessed resulting in serious injuries to Resident A, fractured hip, and staples in her head.
CONCLUSION:	**VIOLATION ESTABLISHED**

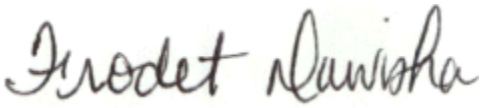
APPLICABLE RULE	
R 400.15306	**Use of assistive devices.**
	(2) An assistive device shall be specified in a resident's written assessment plan and agreed upon by the resident or the resident's designated representative and the licensee.
ANALYSIS:	Based on my investigation and information gathered, Resident A was in a wheelchair supplied by the facility and not specified in her assessment plan completed on 05/15/2020.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15306	**Use of assistive devices.**
	(3) Therapeutic supports shall be authorized, in writing, by a licensed physician. The authorization shall state the reason for the therapeutic support and the term of the authorization.
ANALYSIS:	Based on my investigation and information gathered, Resident A was in a wheelchair supplied by the facility that was not authorized in writing by a licensed physician.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1)(c) Incidents that involve any of the following: (ii) Hospitalization.
ANALYSIS:	Based on my investigation, Resident A was hospitalized on 07/17/2021, 07/27/2021 and 07/30/2021 due to falls incident reports were not submitted within 48 hours of the falls to the adult foster care licensing department.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

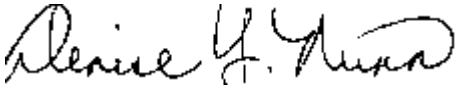
Contingent upon receiving an acceptable corrective action plan, I recommend this special investigation be closed and no change to the status of the license.



09/20/2021

Frodet Dawisha Date
Licensing Consultant

Approved By:



10/07/2021

Denise Y. Nunn Date
Area Manager