GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 5, 2022

Stephen Levy
Addington Place of Clarkston
5700 Water Tower Pl
Clarkston, MI 48346

RE: License #: AH630365890
Investigation #: 2022A1027067
Addington Place of Clarkston

Dear Mr. Levy:

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 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. 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 (517) 241-1970.

Sincerely,

Jessica Rogers

Jessica Rogers, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 285-7433

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630365890
Investigation #:	2022A1027067
Complaint Receipt Date:	06/17/2022
Investigation Initiation Date:	06/17/2022
Report Due Date:	08/17/2022
Licensee Name:	ARHC ARCLRMI01 TRS, LLC
Licensee Address:	106 York Road Jenkintown, PA 19046
Licensee Telephone #:	(248) 625-0500
Administrator:	Scott Nelson
Authorized Representative:	Stephen Levy
Name of Facility:	Addington Place of Clarkston
Facility Address:	5700 Water Tower Pl Clarkston, MI 48346
Facility Telephone #:	(248) 625-0500
Original Issuance Date:	01/20/2015
License Status:	REGULAR
Effective Date:	07/20/2021
Expiration Date:	07/19/2022
Capacity:	72
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was improperly discharged.	Yes
Additional Findings	No

III. METHODOLOGY

06/17/2022	Special Investigation Intake 2022A1027067
06/17/2022	Special Investigation Initiated - Telephone Telephone interview conducted with administrator Scott Nelson to confirm Resident A was an HFA resident and inquired about her hospitalization
06/17/2022	Contact - Telephone call received Voicemail received from Director of Health and Wellness Lucy Noble
06/21/2022	Contact - Telephone call made Voicemail left with Director of Health and Wellness Lucy Noble
06/29/2022	Inspection Completed On-site
06/30/2022	Contact - Document Received Documentation requested at on-site inspection. Requested documentation received from Ms. Noble by email.
07/05/2022	Inspection Completed - BCAL Sub. Compliance
09/08/2022	Exit Conference Conducted by email with authorized representative Stephen Levy

ALLEGATION:

Resident A was improperly discharged.

INVESTIGATION:

On 6/17/2022, the department received a complaint from the online complaint system which read Resident A was transferred to St. Joseph Hospital in Pontiac for altered behaviors from recent medications in which the facility deemed Resident A as “inappropriate” to return. The complaint read Resident A had been discharged without a place to live from the hospital in which her insurance would no longer cover the hospitalization.

On 6/17/2022, I conducted a telephone interview with administrator Scott Nelson who stated Resident A had medication changes that altered her behaviors which required her to be hospitalized three times in the past six months in which she had been at the hospital for two weeks most recently. Mr. Nelson stated the facility had deemed Resident A inappropriate to return to the assisted living on 6/14/2022, the day of her hospital discharge. Mr. Nelson stated a discharge letter was not sent to Resident A.

On 6/29/2022, I conducted an on-site inspection at the facility. I interviewed Mr. Nelson who stated Resident A had discharged from the hospital’s inpatient psychiatric unit to another facility. Mr. Nelson stated the facility had intended for Resident A to return to the facility after hospitalization until the day of her discharge. Mr. Nelson stated the Health and Wellness Director Lucy Noble had assessed Resident A at the hospital in which she demonstrated behaviors. Mr. Nelson stated Ms. Noble’s observations and assessment, as well as the hospital’s discharge instructions and order written by her physician which read, she was inappropriate for assisted living, were reviewed by the facility’s corporate team and she deemed inappropriate to return to their facility based on inability to meet her needs. Mr. Nelson stated he thought Resident A would remain hospitalized after the facility had informed their team that she was not at her baseline in which they would have had an opportunity to reassess her again to return to the facility.

While on-site, I interviewed Ms. Noble who stated she had assessed Resident A at the hospital and upon entry to Resident A’s hospital room, Resident A had yelled at her and seemed angry that Ms. Noble was there. At that time, Ms. Noble stated she requested the hospital nurse stay at bedside with her. Ms. Noble stated Resident A had an aggressive demeanor and yelled at her to get out of her room. Ms. Noble stated Resident A seemed like a “totally different person.” Ms. Noble stated she had known Resident A for approximately 15 years prior in which she had not observed those types of behaviors from her and pleasant with nice personality.

I reviewed Resident A’s face sheet which read she admitted to the facility on 8/14/2012.

I reviewed Resident A’s admission contract dated 4/7/2022 and signed by Resident A’s authorized representative on 4/7/2022 which read in part

8. Transfer for More Appropriate Care.

The Community is licensed as a Home For The Aged and is not designed to provide higher levels of care, such as 24-hour skilled nursing or care for serious psychiatric disorders. You may remain in your Apartment at the Community as long as doing so: (1) is permitted by applicable licensure laws and applicable fire safety standards; and (2) your presence does not create a danger to self or others and, in the judgment of the Community's staff, your care needs and levels of functioning are consistent with those of other residents and with the level of staffing and facilities offered at the Community. If the Community's Executive Director, the Department, or your health care provider determines that it is inappropriate for you to remain in your Apartment, you and your personal representative shall be notified in writing that you must make arrangements for transfer to an appropriate care setting, and this Contract will terminate in accordance with Paragraph 11 below.

11. TERMINATION OF CONTRACT

B. Termination By the Community

The Community may terminate this Contract at any time by giving thirty (30) days prior written notice to you and to your responsible person, if applicable, pursuant to terms hereof. If the Community terminates this Contract, you or your responsible person, as applicable, will continue to be responsible for your Monthly Services Fee, Level of Care Fee, and any other fees payable under this Contract until the thirty (30) day period has expired and you have vacated your Apartment as described in 11(E) below. The Community may terminate this Contract, in its discretion, if any of the following events occur:

> *(4) The community or a health care provider determines that the Community is inappropriate for You and Your condition or that the Community is unable to meet Your care needs;*

I reviewed Resident A's service plan which read her primary diagnosis was bipolar 2 disorder, dementia, depression. The plan in part read *Problematic Expressions (complete for Residents who exhibit problematic behaviors i.e. crying or verbalizing sadness, physical or verbal aggression, frequent call out for help, frequent pacing, refusal of care/meals/meds or valued activities, delusions/hallucinations, threats to harm self/others, spitting, biting, lethargy, obsessing about returning home, sexually inappropriate)* and provided staff with approaches and/or interventions including giving choices to help direct care and tell you what she wants and how it should be done, approach her in a calm and gentle manner, using positive body language and facial expressions, encourage her to participate in activities and programs that may interest her, engage her in "small talk" prior to asking her to do something to help reduce my anxiety and build rapport, please try to keep her environment peaceful and calm as well as help her go to peaceful environment if needed, and if she is upset, to redirect her to an activity or conversation of interest as well as offer her choices whenever possible.

I reviewed Resident A's chart notes from March 2022 through May 2022 which read consistent with staff interviews. The March 2022 chart notes read Resident A had been hospitalized as well as noted an incident of "aggression." The April 2022 chart notes read Resident A "grabbed the others resident's hand and pushed her away with a firm grip and demo x2 rebounded shoves." The May 2022 chart notes read Resident A had increased behaviors of verbal aggression with staff, seeking to go outside unassisted and had entered other resident's rooms without permission. The notes read Resident A had entered another resident's room, verbally attacked the other resident in which the other resident reported to staff that Resident A smacked her on the back. The notes read Resident A was hospitalized on 5/24/2022 for "behavior health."

I reviewed a physician order dated 6/14/2022 prescribed for Resident A which read diagnosis: "Bipolar affective disorder, type I manic severe with Psychotic features." The order read "Resident not appropriate for assisted living."

I reviewed the hospital's discharge documentation which read Resident A was hospitalized from 5/24/2022 to 6/14/2022. The documentation read Resident A's discharge diagnosis was consistent with the physician's order diagnosis. The documentation read consistent with statements regarding Resident A's behaviors as the reason for her hospital admission.

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents; adoption; posting and distribution; contents; additional requirements; discharging, harassing, retaliating, or discriminating against patient exercising protected right; exercise of rights by patient's representative; informing patient or resident of policy; designation of person to exercise rights and responsibilities; additional patients' rights; definitions.**
	(3) The following additional requirements for the policy described in subsection (2) apply to licensees under parts 213 and 217: **(e) A home for the aged resident may be transferred or discharged only for medical reasons, for his or her welfare or that of other residents, or for nonpayment of his or her stay, except as provided by title XVIII or title XIX. A nursing home patient may be transferred or discharged only as provided in sections 21773 to 21777. A nursing home patient or home for the aged resident is entitled to be given reasonable advance notice to ensure orderly transfer or**

	discharge. Those actions shall be documented in the medical record.
For Reference: R 325.1922	**Admission and retention of residents.**
	(15) A home may discharge a resident before the 30-day notice if the home has determined and documented that either, or both, of the following exist: **(a) Substantial risk to the resident due to the inability of the home to meet the resident's needs or due to the inability of the home to assure the safety and well-being of the resident, other residents, visitors, or staff of the home.** **(b) A substantial risk or an occurrence of the destruction of property.** **(16) A home that proposes to discharge a resident for any of the reasons listed in subrule (15) of this rule shall take all of the following steps before discharging the resident:** **(a) The home shall notify the resident, the resident's authorized representative, if any, and the agency responsible for the resident's placement, if any, not less than 24 hours before discharge. The notice shall be verbal and issued in writing. The notice of discharge shall include all of the following information:** **(i) The reason for the proposed discharge, including the specific nature of the substantial risk.** **(ii) The alternatives to discharge that have been attempted by the home, if any.** **(iii) The location to which the resident will be discharged.** **(iv) The right of the resident to file a complaint with the department.**

ANALYSIS:	Review of facility records revealed Resident A had psychiatric diagnosis in which increased behaviors required psychiatric hospitalization. Resident A was deemed not appropriate to return to the facility's level of care by her health care provider which was consistent with the signed resident admission contract, however the facility lacked documentation providing written notification to her and her authorized representative. The contract read the resident, and their authorized representative, shall be notified in writing if the resident was no longer appropriate for their care setting. Based on that information, this allegation was substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 9/7/2022, I left a voicemail with authorized representative Stephen Levy, then shared the findings by email 9/8/2022.

IV. RECOMMENDATION

Contingent upon receipt of acceptable corrective action plan, I recommend the license remain unchanged.

07/05/2022

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Jessica Rogers Date
Licensing Staff

Approved By:

09/07/2022

_____

Andrea L. Moore, Manager Date
Long-Term-Care State Licensing Section