



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

ORLENE HAWKS  
DIRECTOR

March 11, 2023

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

RE: License #: AH630365890  
Investigation #: 2023A1027036  
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. 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 (517) 241-1970.

Sincerely,

A handwritten signature in cursive script that reads "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**

<b>License #:</b>	AH630365890
<b>Investigation #:</b>	2023A1027036
<b>Complaint Receipt Date:</b>	02/01/2023
<b>Investigation Initiation Date:</b>	02/02/2023
<b>Report Due Date:</b>	04/03/2023
<b>Licensee Name:</b>	ARHC ARCLRMI01 TRS, LLC
<b>Licensee Address:</b>	106 York Road Jenkintown, PA 19046
<b>Licensee Telephone #:</b>	(248) 625-0500
<b>Administrator:</b>	Denise Lugar
<b>Authorized Representative:</b>	Stephen Levy
<b>Name of Facility:</b>	Addington Place of Clarkston
<b>Facility Address:</b>	5700 Water Tower Pl Clarkston, MI 48346
<b>Facility Telephone #:</b>	(248) 625-0500
<b>Original Issuance Date:</b>	01/20/2015
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	07/20/2022
<b>Expiration Date:</b>	07/19/2023
<b>Capacity:</b>	72
<b>Program Type:</b>	AGED

**II. ALLEGATION(S)**

	<b>Violation Established?</b>
Staff were not trained.	Yes
Residents were neglected.	No
Additional Findings	No

**III. METHODOLOGY**

02/01/2023	Special Investigation Intake 2023A1027036
02/02/2023	Special Investigation Initiated - Letter Email sent to Mr. Nelson requesting a resident census and employee list
02/03/2023	Contact - Document Received Email received from Mr. Nelson with requested documentation
03/06/2023	Inspection Completed On-site
03/06/2023	Inspection Completed-BCAL Sub. Compliance
04/11/2023	Exit Conference Conducted by voicemail with authorized representative Stephen Levy

**ALLEGATION:**

**Staff were not trained.**

**INVESTIGATION:**

On 2/1/2023, the Department received a complaint forwarded by Adult Protective Services (APS) which read staff were not properly trained. APS did not open an investigation pertaining to the allegations.

On 3/6/2023, I conducted an on-site inspection at the facility. I interviewed interim administrator Diane Lugar who stated staff training was completed in the *Relias* program.

While on-site, I reviewed Employee #2, #3 and #4's training records. Ms. Lugar stated the employee's date of hire was changed to 3/1/2022 due to becoming new employees under "SLC" Senior Lifestyle Community. Employee #2's records revealed she was hired in 2018 and received training regarding emergency procedures dated 1/11/2018 and completed medication pass observation training 10/14/2019, 10/15/2019, 10/16/2019 and 10/18/2019. Employee #2's *Relias* transcript read she completed some trainings on 12/29/2020 and the rest of the training was completed on various dates afterwards. Employee #3's records revealed she was hired 11/18/2020 in which some *Relias* training was completed on various dates starting in January 2021 with the earliest starting 1/14/2021. Employee #4's file lacked training documentation.

While on-site, I interviewed Employee #4 who stated she started in January 2023 and completed training. Employee #4 stated the training records were maintained with an assistant director who was not on-site that day.

On 3/10/2023, email correspondence with Ms. Lugar read Employee #4 lacked verification training was completed.

<b>APPLICABLE RULE</b>	
<b>R 325.1921</b>	<b>Governing bodies, administrators, and supervisors.</b>
	<p><b>(1) The owner, operator, and governing body of a home shall do all of the following:</b></p> <p style="padding-left: 40px;"><b>(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.</b></p>
<b>For Reference: R 325.1931(5)</b>	<b>Employees; general provisions.</b>
	<p><b>(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:</b></p> <p style="padding-left: 40px;"><b>(a) Reporting requirements and documentation.</b></p> <p style="padding-left: 40px;"><b>(b) First aid and/or medication, if any.</b></p> <p style="padding-left: 40px;"><b>(c) Personal care.</b></p> <p style="padding-left: 40px;"><b>(d) Resident rights and responsibilities.</b></p> <p style="padding-left: 40px;"><b>(e) Safety and fire prevention.</b></p> <p style="padding-left: 40px;"><b>(f) Containment of infectious disease and standard precautions.</b></p> <p style="padding-left: 40px;"><b>(g) Medication administration, if applicable.</b></p>

<b>ANALYSIS:</b>	Review of Employee #2 and #3's files revealed although <i>Relias</i> training was completed, the files lacked evidence of an organized program of training to ensure competency related to the function and responsibility of the employee's role during a timeframe in which they would have been training with another employee. Additionally, Employee #4's file lacked evidence of training records in which she was working independently with residents during the on-site inspection. Based on this information, this allegation was substantiated.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**ALLEGATION:**

**Residents were neglected.**

**INVESTIGATION:**

On 2/1/2023, the Department received a complaint forwarded by Adult Protective Services (APS) which read most residents had falls and bruises due to a lack of supervision. The complaint read residents were denied their basic needs. The complaint read staff deny residents their basic needs such as getting them water and yell at residents if their briefs are too wet. The complaint read residents lacked supervision. APS did not open an investigation pertaining to the allegations.

On 3/6/2023, I conducted an on-site inspection at the facility. I interviewed Ms. Lugar who stated she was the interim administrator. Ms. Lugar stated the facility was well staffed.

I interviewed Employee #1 who stated the facility maintained a hydration and snack station on the first floor in which residents could utilize 24 hours per day. Employee #1 stated most residents received showers twice weekly, but some requested showers once weekly, such as Resident A.

While on-site, I interviewed Employee #2 who stated staff provided "good care." Employee #2 stated she has never observed any staff yelling at a resident. Employee #2 stated residents were provided fresh waters on her shift (first shift) and could request a snack, if wanted. Employee #2 stated many residents kept snacks in their rooms.

While on-site, I interviewed Employee #4 whose statements were consistent with previous staff interviews. Employee #4 stated she had not observed staff yelling at residents.

While on-site, I interviewed Resident A who stated the facility offered beverages such as water, juice, and coffee. Resident A stated staff provided waters and sometimes he requested water from staff in which was provided. Resident A stated the facility provided snacks such as potato chips and cookies in which he thought they could offer more variety. Resident A stated staff visited his room frequently. Resident A stated staff assisted him with showers because he was a fall risk. Resident A stated "I get along with staff. They treat everyone fine." I observed Resident A had three 12-ounce Styrofoam cups at bedside, as well as box of snacks. I observed Resident A's arms and legs in which did not appear to have bruising.

While on-site, I interviewed Resident B who stated she was mostly independent and completed her own showers, however staff checked on her. Resident B stated she maintained snacks in her room and obtained her own water in her apartment. Resident B stated, "everyone here is pretty nice." I observed Resident B's arms and legs in which did not appear to have bruising.

While on-site, I interviewed Resident C who stated who stated she obtained filled her own water bottle and maintained snacks in her apartment. Resident C stated she often requested coffee, in which sometimes they were unable to provide before breakfast hours. Resident C stated staff "are very nice." Resident C stated she received assistance from staff with her showers which were every Tuesday and Friday. I observed Resident C's arms and legs in which did not appear to have bruising.

While on-site, I observed 23 residents who appeared well groomed and dressed in clean clothing during their lunch meal. I observed a staff member walking through the dining room area with a cart of assorted beverages such as but not limited to coffee, water, and juices. I observed staff were friendly to residents which was reciprocated.

While on-site, I observed three staff on duty, as well as one staff member in training and one staff member assigned to provide showers.

While on-site, I observed a list of residents in the medication room in which read three residents who required two-person assistance on first floor and three residents who required two-person assistance on second floor.

While on-site, I observed a document titled *AL Daily Routine* in the medication room which read in part for first and second shifts staff were to assist residents with their morning routine, showers if it was their shower day, pick up resident's rooms, empty trash, take out trash, answer call lights, assist with taking residents to breakfast, and were to assist residents with toileting. The document read all tasks were completed for lunch and dinner meals as well. The document read midnight shift was to conduct room checks every two hours for residents who received checks.

While on-site, I observed the hydration station which consisted of a large drink dispenser with several cups next to it and a basket of snacks including but not limited to chips, peanut butter crackers, goldfish crackers, and cookies.

I reviewed Resident A's service plan updated on 2/3/2023 which read in part he was independent with ambulation with a walker and staff were to monitor him for falls. The plan read in part he could bathe without physical assistance but required reminding or standby assistance.

I reviewed Resident A's shower sheets dated 1/26/2023 through 2/28/2023 which read he received showers weekly and documented when he refused.

I reviewed Resident A's incident report dated 12/28/2022 which read he was observed on the floor and there was no injury.

I reviewed Resident B's service plan updated on 2/6/2023 which read in part she was had occasional disorientation in which she required supervision and oversight for safety. The plan read in part read she may require staff assistance with ambulation and required a walker. The plan read in part Resident B required staff assistance with bathing, grooming, and dressing.

I reviewed Resident B's shower sheets dated 2/3/2023 through 3/3/2023 which read she received showers twice weekly.

I reviewed Resident B's incident report dated 11/12/2022 which read she was observed on the floor and there was no injury.

I reviewed Resident C's service plan updated 7/29/2022 which read in part she required one person assist for bathing, grooming and personal hygiene.

I reviewed Resident C's shower sheets dated 2/3/2023 through 3/3/2023 which read she received showers twice weekly.

I reviewed Resident C's incident report dated 11/12/2022 which read she was reaching for something on her table and fell from her wheelchair hitting her knee in which she had right leg bruise.

I reviewed the Department's facility file which there was on incident report dated 9/27/2022 which had reported a resident was observed next to his bed on the floor and he was sent to the hospital, then subsequently admitted for right hip fracture.

I reviewed the facility's staffing schedule from 2/1/2023 through 2/28/2023. The schedule read there was usually one medication technician and two aides assigned to first and second shifts. The schedule read on third shift there was one medication technician and one aide assigned.

<b>APPLICABLE RULE</b>	
<b>R 325.1931</b>	<b>Employees; general provisions.</b>
	<b>(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.</b>
<b>For Reference R 325.1952</b>	<b>Meals and special diets.</b>
	<b>(1) A home shall offer 3 meals daily to be served to a resident at regular meal times. A home shall make snacks and beverages available to residents.</b>
<b>ANALYSIS:</b>	Review of facility documentation revealed there were residents who required one or two-person assistance. Observations, resident, and staff attestations revealed resident's needs were met consistent with their service plans. Review of resident's medical records revealed they had falls but there was insufficient evidence to support it was due to lack of supervision as evidence by the staff schedule. Additionally, observations revealed water and snacks were offered. Based on this information, this allegation was not substantiated.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

#### IV. RECOMMENDATION

Contingent upon an acceptable corrective action plan, I recommend the status of this license remain unchanged.

*Jessica Rogers*

03/13/2023

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Jessica Rogers  
Licensing Staff

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Date

Approved By:

*Andrea Moore*

04/10/2023

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

\_\_\_\_\_  
Date