GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

Stephen Levy
Addington Place of Northville
42010 W Seven Mile Road
Northville, MI 48167

March 14, 2024

RE: License #: AH820378951
Investigation #: 2024A1022023
Addington Place of Northville

Dear Stephen 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.

Please review the enclosed documentation for accuracy and contact me with any questions.

Sincerely,

Barbara P. Zabitz, R.D.N., M.Ed.
Health Care Surveyor
Health Facility Licensing, Permits, and Support Division
Bureau of Community and Health Systems
Department of Licensing and Regulatory Affairs
Mobile Phone: 313-296-5731
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enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH820378951
Investigation #:	2024A1022023
Complaint Receipt Date:	02/21/2024
Investigation Initiation Date:	02/22/2024
Report Due Date:	03/22/2024
Licensee Name:	ARHC APNVLMI01 TRS, LLC
Licensee Address:	c/o Healthcare Trust, Inc 650 Fifth Ave New York, NY 10019
Licensee Telephone #:	(212) 415-6551
Administrator:	Maurizio Palombi
Authorized Representative:	Stephen Levy
Name of Facility:	Addington Place of Northville
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:	08/10/2023
Expiration Date:	08/09/2024
Capacity:	80
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
The Resident of Concern (ROC) had an injury that was consistent with physical mistreatment or abuse.	Yes

III. METHODOLOGY

02/21/2024	Special Investigation Intake 2024A1022023
02/22/2024	Special Investigation Initiated - Telephone Complainant interviewed by phone.
03/08/2024	Contact - Telephone call made. Investigation conducted remotely via videoconference.
03/14/2024	Exit Conference

ALLEGATION:

The Resident of Concern (ROC) had an injury that was consistent with physical mistreatment or abuse.

INVESTIGATION:

On 02/21/2024, the Bureau of Community and Health Systems (BCHS) received a referral from Adult Protective Services (APS) that in part read, “At 7:15 PM on 11/26/2023, while [name of the Resident of Concern (ROC)] was still a resident of Addington Place of Northville, she was observed to have bruising on her left arm that appeared to be the result of abuse or external force. The bruising was square in shape and appears to have been caused by [name of the ROC]'s arm forcefully hitting a wall mounted thermostat. [Name of the ROC] is physically incapable of moving fast enough to cause that kind of injury. [Name of the ROC] is able to walk

without the aid of a cane or walker. Balance has not been an issue for [name of the ROC], and it is unlikely she fell into the thermostat. [Name of the ROC] is able to put on her socks, shoes, and keep her shoes tied. [Name of the ROC]'s pants are hemmed to an appropriate length and do not create hazards for her. It is suspected that staff on duty at the time, name(s) unknown, had been using some type of force with [name of the ROC] that resulted in her hitting the thermostat and causing the injury.

The referral was marked, “Denied,” signifying that APS had determined they would not be investigating the allegations.

On 02/22/2024, I interviewed the complainant by phone. The complainant identified himself as the ROC’s son-in-law and explained that he and the ROC’s daughter had moved the ROC out of the facility at the time they discovered the bruising on the ROC’s left shoulder. The complainant went on to say that he had extensive correspondence with the facility’s administrator regarding this injury and the family’s suspicion that it was the result of physical mistreatment or abuse. The complainant stated that the facility administrator had not gotten back to anyone in the ROC’s family about their concerns.

According to an email exchange that occurred between the facility’s administrator and the ROC’s daughter, on 11/26/2023, the ROC’s daughter wrote the administrator, “… when I (the ROC’s daughter) was changing her (the ROC) into pajamas we noticed a very large bruise on her left shoulder area. I (the ROC’s daughter) do not know when or how this happened but I do know it was not her on Thursday (11/23/2023) when I showered her twice at my home and I gave her a shower last night (11/25/2023) when we were here…They (facility staff) have checked the log books in the kitchen and there was nothing reported in the logs regarding the bruise…I’m not sure if this is considered elder abuse.” According to a second email exchange, on 12/06/2023, from the ROC’s daughter to the administrator, “When you (the administrator) and I (the ROC’s daughter) spoke on Monday, November 27,2023, you assured me that you would have your internal investigation finalized no later than Thursday, November 30, 2023…During the time we had her (the ROC) home with us, we waited patiently for an update or follow up, but nothing…”

On 03/08/2024, I interviewed the administrator and the wellness director remotely, via a videoconference call. The administrator acknowledged that he while he questioned the staff members who were present during the day shift on 11/26/2023, he did not make any notes, as none of the employees admitted to having any knowledge of how the bruising occurred. According to the facility’s Grievance Procedure Policy, the facility’s policy was to document “a written summary of the grievance and remediation/correction plan” in the facility’s grievance log as well as “Grievance forms, logs and documented resolutions…” The administrator acknowledged that he did not adhere to the facility policy. The only documentation prepared by the facility was an incident report (IR). According to the IR, on

11/26/2023, a family reported to staff that they had found a bruise on the ROC. According to the IR, “This writer (shift supervisor/medication technician #1) observed resident (the ROC) laying in bed sleeping, seen bruise on the top of her left side on the back of her shoulder and appears to be some color of yellow. Did not show no signs of pain or though (throughout) the day…” The only other notation on the IR indicated that a voicemail was left for the ROC’s health care provider. The administrator stated that the facility assumed that the ROC acquired the bruising by accidentally stumbling into the wall-mounted thermostat. He had no additional explanation.

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.**
	(2) The policy describing the rights and responsibilities of patients or residents required under subsection (1) shall include, as a minimum, all of the following: **(l) A patient or resident is entitled to be free from mental and physical abuse**
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following: **(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.**
For Reference: R325.1901	**Definitions.**
	(16) "Protection" means the continual responsibility of the home to take reasonable action to ensure the health, safety, and well-being of a resident as indicated in the resident's service plan, including protection from physical harm, humiliation, intimidation, and social, moral, financial, and personal exploitation while on the premises, while under the supervision of the home or an agent or employee of the

	home, or when the resident's service plan states that the resident needs continuous supervision.
ANALYSIS:	The facility did not conduct a systematic investigation into an allegation of physical abuse in accordance with the established procedure of the facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

I reviewed the findings of this investigation with the administrator on 3/14/2024. When asked if there were any comments or concerns with the investigation, the administrator stated that there were none.

IV. RECOMMENDATION

Contingent upon an acceptable corrective action plan, I recommend no change to the status of the license.

03/14/2024

Barbara Zabitz — Date
Licensing Staff

Approved By:

03/11/2024

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