GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 26, 2024

Tyler May
Addington Place of Clarkston
5700 Water Tower Pl
Clarkston, MI 48346

RE: License #: AH630365890
Investigation #: 2024A1035031
Addington Place of Clarkston

Dear Tyler May:

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,

Jennifer Heim, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(313) 410-3226

enclosure

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

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AH630365890 |
| | |
| **Investigation #:** | 2024A1035031 |
| | |
| **Complaint Receipt Date:** | 03/25/2024 |
| | |
| **Investigation Initiation Date:** | 03/25/2024 |
| | |
| **Report Due Date:** | 05/24/2024 |
| | |
| **Licensee Name:** | ARHC ARCLRMI01 TRS, LLC |
| | |
| **Licensee Address:** | 106 York Road<br>Jenkintown, PA 19046 |
| | |
| **Licensee Telephone #:** | (248) 625-0500 |
| | |
| **Administrator:** | Tina Young |
| | |
| **Authorized Representative:** | Tyler May |
| | |
| **Name of Facility:** | Addington Place of Clarkston |
| | |
| **Facility Address:** | 5700 Water Tower Pl<br>Clarkston, MI 48346 |
| | |
| **Facility Telephone #:** | (248) 625-0500 |
| | |
| **Original Issuance Date:** | 01/20/2015 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 07/20/2023 |
| | |
| **Expiration Date:** | 07/19/2024 |
| | |
| **Capacity:** | 72 |
| | |
| **Program Type:** | AGED |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Lack of supervision and care of Resident A, staff training, and food program concerns. | Yes |
| Additional Findings | No |

The complainant identified some concerns that were not related to licensing rules and statues for a home for the aged. Therefore, only specific items pertaining to homes of the aged provisions of care were considered for investigation. The following items were that that could be considered under the scope of licensing.

## III. METHODOLOGY

| | |
|---|---|
| 03/25/2024 | Special Investigation Intake 2024A1035031 |
| 03/25/2024 | Special Investigation Initiated - Letter |
| 05/21/2024 | Contact - Face to Face |
| | |
| | |
| | |

## ALLEGATION:

Lack of supervision and care of Resident A, staff training, and food program concerns.

**INVESTIGATION:**

On March 25, 2024, the department received a complaint through the online complaint system, complainant concerns include the following: Resident A falling multiple times, lack of supervision, lack of staff training, lack of notification to hospice agency, emergency call cord not working in room, ADL assistance not being performed daily, non-staff members assisting with meal pass, and poor food service management.

On May 21, 2024, an onsite investigation was conducted. While onsite, I interviewed Staff Person (SP)1 who states Resident A was “very restless” multiple intervention were implemented without success of preventing future falls. SP1 states family was very attentive and present who declined medication to treat Resident A restlessness. SP1 states there was 1 med tech and 1 caregiver scheduled to unit/ building Resident A resided in with an average census of 10 at that time. SP1 states all staff are trained

upon hire with competency check off. SP1 states post incidence and change in condition assigned hospice agencies are notified giving the assigned nurse the opportunity to come to the facility to complete further evaluation. SP1 states an incident report “IR” are filled out post fall occurrences and incidences. SP1 is unaware of family members assisting with passing meal trays.

While on site I interviewed Tina Young, Executive Director, who states she’s newly appointed to the position but will assist in any way she can. Tina provided Resident A’s service plan, admission contract, incident and accident policy, and average daily census for the months of January through June for the unit/ building Resident A resided.

While onsite, I interviewed SP2 who states Resident A was “very restless” and family was at the bedside throughout the day. SP2 states family had a hard time accepting Resident A’s progression with advanced dementia. SP2 states all staff are educated upon hire and throughout the year. Med techs and caregivers work together to complete ADL care for each resident. Resident A resided in building 58 where there were only 6 residents during this time.

While onsite I interviewed SP3 who states all staff members are trained during orientation and through Relias training with med techs having additional training on medication administration. SP3 states when a fall occurs staff call for additional assistance, resident vital signs are taken, resident is moved if able to move extremities, family is notified, hospice is notified, and an IR is completed. SP3 recalls Resident A falling on multiple accounts stating she was very anxious and attempted to self-transfer often. SP3 states the facility shares one med tech between the two memory care buildings leaving one caregiver in each building potentially alone. “We are always short staffed.”

While onsite I interviewed SP4 who states Resident A was “restless and liked pushing furniture around. Resident A’s husband was looking for 1:1 care but he was informed the facility does not offer 1:1 care. When a resident falls range of motion is preformed prior to moving the resident, vital signs are taken, notification to the supervisor, family, and hospice then occurs. In the event there is an emergency resident is sent to the hospital for further evaluation. Meals are brought to the building from the main kitchen and set up in the steam table in each memory care building. Staff are the only person allowed to serve food. SP4 states I have never seen family or non-staff members pass trays.”

While onsite I interviewed SP5 who states Resident A was bed ridden at one point then improved to being able to sit up in the wheelchair. Resident A was very restless and fell often. The staff were supposed to check on her every two hours. SP5 states she has never seen non-staff members serve food.

While onsite I interviewed SP6 who states the menu is a revolving menu that is posted for family, visitors, and residents to review. An alternative menu is available for those

residents wishing to have a different meal option. Meals are prepared in the main kitchen then delivered to each building. Kitchen staff place meals in warmers and care staff serve residents.

| **APPLICABLE RULE** | |
|---|---|
| **R 325.1921** | **Governing bodies, administrators, and supervisors.** |
| | **(1) The owner, operator, and governing body of a home shall do all of the following:**<br>**(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.** |

| | |
|---|---|
| **ANALYSIS:** | Through direct observation Residents in both memory care units/ buildings were in the dining areas waiting to be served lunch. All observed residents dressed appropriately and well groomed.<br><br>Soap dispensers and hand sanitizer noted within the facility. Staff interviews provided that there have not been problems that they are aware of with the emergency call cords.<br><br>SP1, 2, 3 and 4 education record reviewed. Each staff member reviewed received fall training as well as ADL, resident rights, and safety training.<br><br>Administrator states the facility continues to interview and hire staff. Staffing goals for memory care are two caregivers and one med tech per building as census allows.<br><br>Through record review the service plan indicates Resident A "Fall Potential" and for the "staff to monitor resident for falls and report to appropriate team members" There are no fall preventative measure noted on Resident A's service plan. Through hospice progress notes review Resident A had orders in place to alleviate moments of agitation and restlessness. One hospice progress notes states Med Tech not available to fill and count Morphine related to being in the other building and not returning.<br><br>Facility provided multiple incident reports that were not complete with missing pertinent data. Facility did not implement measure to reduce fall occurrences. The only fall intervention mention was for staff to monitor resident every two hours and assist with ADL's. Facility failed to maintain safety and limit fall occurrences.<br><br>Therefore, this allegation has been substantiated. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

## IV. RECOMMENDATION

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

05/23/202

Jennifer Heim — Date

Licensing Staff

Approved By:

06/13/2024

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