GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 3, 2025

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

RE: License #: AH630365890
Investigation #: 2025A1035031
Addington Place of Clarkston

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 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 (517) 284-9730.

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 #:	2025A1035031
Complaint Receipt Date:	01/28/2025
Investigation Initiation Date:	01/28/2025
Report Due Date:	03/28/2025
Licensee Name:	ARHC ARCLRMI01 TRS, LLC
Licensee Address:	106 York Road Jenkintown, PA 19046
Licensee Telephone #:	(248) 625-0500
Administrator:	Quintina Young
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:	08/01/2024
Expiration Date:	07/31/2025
Capacity:	72
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
The facility is short-staffed. Resident A waits a long time for staff assistance.	Yes
Resident A care needs are not being met.	Yes
Additional Findings	No

III. METHODOLOGY

01/28/2025	Special Investigation Intake 2025A1035031
01/28/2025	Special Investigation Initiated - Letter
01/28/2025	APS Referral
02/19/2025	Contact - Face to Face
02/28/2025	Inspection Complete. BCAL Full Compliance.
03/03/2025	Exit Conference.

ALLEGATION:

The facility is short-staffed. Resident A waits a long time for staff assistance.

INVESTIGATION:

On January 28,2025, the Department received a complaint forwarded from Adult Protective Services (APS) which read:

> "Resident A presses his button for assistance, but help does not arrive for hours. The facility is extremely short staffed and unable to provide adequate care."

On February 19, 2025, an onsite investigation was conducted while onsite I interviewed Administrator Quintina Young "Tina" who states the facility staffing goals are 2 Med-Tech/ 3 Care staff for day shift and1 Med-Tech and 1 Care staff for midnights. The current average daily census is 46 residents.

While onsite I interviewed Resident A who states there are long wait times that are "getting worse." The staff on day shift are more attentive and answer the call light more promptly. Resident A states they take "okay" care of me.

While onsite I interviewed Staff Person (SP)1 who states staffing is okay when everyone comes to work. SP1 states the residents' needs are being met. SP1 who states Resident A's needs are being met when she's here, but she cannot account for anyone else. SP1 states Resident A is particular with care and requires extra time.

Through record review, Resident A had multiple call light wait times greater than 15 minutes, including several response times greater than 45 minutes, with an average collective wait time of 19 minutes.

Through record review facility staffs according to staffing goals.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(5) The home shall have adequate and sufficient staff on duty at all times who are awake, fully dressed, and capable of providing for resident needs consistent with the resident service plans.
ANALYSIS:	Through interview of Resident A, he states he has long call light wait times. Through record review, Resident A average call light time is 19 minutes. There are several call light wait times greater than 45 minutes during the week 2/1/2025 through 2/20/2025. Based on information noted this allegation has been substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A care needs are not being met.

INVESTIGATION:

On January 28, 2025, the Department received a complaint forwarded from Adult Protective Services (APS) which read:

> “Resident A is often observed severely soiled in urine from his elbows all the way to his knees. Resident A has limited mobility and requires a sling or lift to be put into bed. He uses a urinal in bed and often spills the urine on himself as he is trying to collect his urine without assistance. Resident A has severe skin break down due to being left in moisture for long periods of time. The staff deliver Resident A meals in Styrofoam containers instead of dishes. Resident A has not been out of his room in a year and has not been exposed to the common areas with other residents. There are concerns of severe neglect.”

On February 19, 2025, an onsite investigation was conducted. While onsite I interviewed SP2 who states Resident A often refuses care and refuses to get out of bed. SP2 states Resident A receives wound care services through home care.

While onsite, I interview Resident A who states he gets “okay care.” Resident A states he was working with the former Wellness Director, but she no longer works at the facility. Resident A continues to state his wheelchair is broken, he’s unable to sit in it for a long period of time, and the chair will not fit through the door. Resident A states he would like to get up and out in the community but is unable.

While onsite, I interviewed the Administrator who states SP2 has attempted to work with Resident A without success. SP2 has educated the staff on documenting Resident A refusals related to the refusals occurring so often. The Administrator states there has been conversation with Resident A related to the possibility of moving to a facility that offers a higher level of care.

While onsite I interviewed SP1 who states she has a “routine” she goes by when providing care to Resident A. Resident A is unable to sit up in the wheelchair related to it being ill fitting and not functioning properly.

Through record review and interview, Resident A requires 2-3 persons to provide care and a Hoyer lift for transfers. Resident A states he would like to come out of room but is unable to related to an improperly fitted and uncomfortable wheelchair.

Upon progress note review there are no notes indicating conversation related to refusal of care, improperly fitting wheelchair, potential move to a facility that can provide higher levels of care. No documentation noted on measures taken to improve quality of care. There was one page with a couple handwritten notes related to “behavior charting” provided related to Resident A declines care being offered and transfers to wheelchair.

On February 20, 2025, the Administrator sent a follow up email related to Resident A’s wheelchair which stated “We have located a second chair that belongs to Resident A. We attempted to assist him; however, he was not receptive at the time. Nonetheless, we will remain persistent and follow your guidance, allowing him to make decisions as each day presents new opportunities for us all.”

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(1) Personal care and services that are provided to a resident by the home shall be designed to encourage residents to function physically and intellectually with independence at the highest practical level. Page 11 ***Courtesy of www.michigan.gov/orr*** **(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.**
ANALYSIS:	Based on interview and record review, Resident A's care needs are not being met. There is minimal documentation related to Resident A refusal of care and refusing to transfer to wheelchair. Based on the information noted above, 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 remains unchanged.

02/27/2025

Jennifer Heim, Health Care Surveyor Date
Long-Term-Care State Licensing Section

Approved By:

02/28/2025

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