



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

February 24, 2026

Stephen Levy
ARHC ARCLRMI01 TRS, LLC
5900 Water Tower PL
Clarkston, MI 48346

RE: License #: AL630365575
Investigation #: 2026A0626005
Addington Place of Clarkston 1

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 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 (248) 972-9136.

Sincerely,

A handwritten signature in cursive script that reads "Sara E. Shaughnessy". The signature is written in black ink and is positioned below the word "Sincerely,".

Sara Shaughnessy, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W Grand Blvd, Suite 9-100
Detroit, MI 48202
(248) 320-3721

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL630365575
Investigation #:	2026A0626005
Complaint Receipt Date:	12/05/2025
Investigation Initiation Date:	12/05/2025
Report Due Date:	02/03/2026
Licensee Name:	ARHC ARCLRMI01 TRS, LLC
Licensee Address:	27th Floor - 540 Madison Ave New York, NY 10022
Licensee Telephone #:	(248) 625-0500
Administrator:	Stephen Levy
Licensee Designee:	Stephen Levy
Name of Facility:	Addington Place of Clarkston 1
Facility Address:	5900 Water Tower Pl Clarkston, MI 48346
Facility Telephone #:	(248) 625-0500
Original Issuance Date:	06/19/2015
License Status:	REGULAR
Effective Date:	09/06/2025
Expiration Date:	09/05/2027
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED MENTALLY ILL ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was enrolled in a hospice program and had an advanced directive to not resuscitate. When he was found non-responsive, the direct care staff member contacted 911 instead of the hospice agency and resuscitation attempts were made.	Yes
Resident A did not receive his comfort medications the night he passed away.	No

III. METHODOLOGY

12/05/2025	Special Investigation Intake 2026A0626005
12/05/2025	APS Referral A referral was not made to Adult Protective Services due to the resident being deceased.
12/05/2025	Special Investigation Initiated - Telephone I initiated the investigation by completing a telephone interview with Relative A1.
12/08/2025	Contact - Face to Face I completed an onsite investigation at Addington Place Clarkston. I completed an interview with Kara Fraser, program director.
12/12/2025	Contact - Telephone call made I attempted a telephone interview with direct care staff member, Andre Cade. I left a message requesting a return call.
12/12/2025	Contact - Telephone call received I received a phone call from the number I had for direct care staff member, Andre Cade. When I introduced myself, the call was disconnected. I attempted to call back and it went to voicemail. I left a message.
12/15/2025	Contact - Telephone call made I attempted a phone interview with direct care staff member, Andre Cade. A message was left requesting a return call.

12/26/2025	Contact - Telephone call made I attempted a phone interview with direct care staff member, Andre Cade. A message was left requesting a return call. Right after I left the message, I received a phone call from Mr. Cade's number and as soon as I introduced myself, he disconnected the call.
01/05/2026	Contact - Telephone call made I attempted a phone interview with direct care staff member, Andre Cade. A message was left requesting a return call.
01/06/2026	Contact - Document Sent I sent an email to program director, Kara Fraser, requesting names of other direct care staff members who were working the night Resident A passed away.
01/16/2026	Contact - Document Sent I sent a follow-up email to program director, Kara Fraser, requesting contact information for other direct care staff members who worked the night Resident A passed away.
01/20/2026	Contact - Document Sent I sent an email to licensee designee, Stephen Levy, requesting assistance with obtaining information for other staff members who may have been working on the night Resident A passed away.
01/21/2026	Contact - Telephone call made I attempted to contact the licensee designee, Stephen Levy, via telephone. I left a message requesting a return call.
01/23/2026	Contact - Document Sent I sent a follow-up email regarding my request for direct care staff members names and numbers.
01/23/2026	Contact - Document Received I received an email from licensee designee, Stephen Levy, indicating he will have someone contact me with the information I requested.
01/27/2026	Contact - Document Received I received an email from Maggie Canny, executive director at Addington Place of Clarkson, containing names and numbers of other direct care staff members working the night Resident A passed away.

01/27/2026	<p>Contact - Telephone call made I completed a telephone interview with direct care staff member, Kyle Dixon.</p> <p>I attempted telephone interviews with direct care staff members, Tiara Chapman, Adriyana Cuerton, and Brittany Robbins. Messages were left requesting a return phone call.</p>
01/30/2026	<p>Contact - Telephone call made I completed a telephone interview with direct care staff member, Tiara Chapman.</p> <p>I attempted telephone interviews with direct care staff members, Adriyana Cuerton and Brittany Robbins. Messages were left requesting a return phone call.</p>
02/03/2026	<p>Exit conference I completed an exit conference with licensee designee, Stephen Levy, via telephone.</p>

ALLEGATION:

Resident A was enrolled in a hospice program and had an advanced directive to not resuscitate. When he was found non-responsive, the direct care staff member contacted 911 instead of the hospice agency and resuscitation attempts were made.

INVESTIGATION:

On 12/05/2025, I received the complaint, via email, indicating Resident A had been at Addington Place of Clarkston where he passed away on 09/02/2026. It was alleged that Resident A was enrolled in hospice and had an advanced directive to not resuscitate. The facility was instructed to contact hospice if he were found non-responsive. On 09/02/2025, Resident A was found non-responsive and 911 was called, resuscitation attempts were made and Resident A was pronounced deceased.

I initiated the investigation by completing a telephone interview with Relative A1. He took Resident A to Addington Place Clarkston for hospice. Resident A was admitted on 08/29/2025 and Relative A1 received a phone call on 09/02/2025, informing him that Resident A had been found non-responsive that morning and had passed away. He went there to see Resident A and was told he had to wait due to him having a tube in his neck due to paramedics trying to revive him. Resident A had an advanced directive, indicating he did not want to be resuscitated. They did not follow his wishes or the instructions from hospice.

On 12/08/2025, I completed an unannounced onsite investigation at Addington Place Clarkston. I completed an interview with program director, Kara Fraser. Ms. Fraser did not have a chance to work with Resident A, he was admitted on a Friday, then passed away on Tuesday morning. He was admitted on hospice, after being discharged from a rehabilitation center. He was diagnosed with Alzheimer's and was declining fast. On his day of admission, 08/29/2025, he was lethargic, had a poor appetite, and need total assistance. He was very sick and weak. On 09/02/2025, direct care staff member, Andre Cade, was working and he is the one who found Resident A. Mr. Cade started CPR and had contacted 911 and when paramedics arrived, they ended up stabbing him in the neck. He was found around 5am. Resident A had an advanced directive, with Resident A's wishes not to be resuscitated. Mr. Cade had not been working there very long and may not have been aware of the advanced directive. He has since had his employment terminated, not due to this incident. She provided me with his contact information.

Ms. Fraser provided me with documents from Resident A's file.

There is a post incident investigation report signed by Maggie Canny. The report indicates that while rounding, the med tech observed, unresponsive, in his room and 911 was called. The report indicates there were no violations found, but care staff was provided retraining.

Resident A's Michigan AFC Health and Service Evaluation Results and Service Plan notes that Resident A's code status is do not resuscitate (DNR). It is also noted that Resident A had no impairment with responding to verbal commands, had no sensory defect which would limit his ability to feel or voice pain or discomfort. Resident A was unable to utilize the emergency response system or how to activate the emergency call system.

In the provided documents, there is a durable power of attorney document. The document indicates Resident A did not wish to receive medical treatment or health care that will only postpone the moment of his death from an incurable and terminal condition, prolong an irreversible coma, or to continue medical treatment under any circumstances where his medical condition is such that the burdens of the treatment outweigh the expected benefits or his condition is such that his physical or cognitive abilities are significantly and permanently impaired. Resident A initialed that he did not want cardiopulmonary respiration, mechanical respiration, tube hydration, tube nutrition, antibiotics, and he did want maximum pain relief, even it would hasten his death.

In the file is a document from Heart-to-Heart Hospice regarding notification procedures at the time of death. The document indicates that a phone call should be made to the Oakland County Sheriff at their non-emergency line. There is another document from Heart-to-Heart Hospice with large letters stating, "DO NOT CALL 911", and it has the phone number for the hospice agency to call.

I attempted to complete a phone interview with Andre Cade on 12/12/2025, 12/15/2025, 12/26/2025, and 01/05/2026. I left messages requesting a return phone call at each attempt. On 12/12/2025 and 12/26/2025, I received a phone call from Mr. Cade and when I answered the phone and identified myself, he disconnected the phone call.

On 01/08/2026, I sent an email to program director, Kara Fraser, asking if there had been another direct care staff member working the evening of 09/01/2025. I sent a follow up email on 01/16/2026.

On 01/20/2026, I sent an email to licensee designee, Stephen Levy, requesting assistance on obtaining the requested information.

On 01/21/2026, I attempted phone contact with the licensee designee and left a message requesting a return call.

On 01/23/2026, I sent a follow up email to the licensee designee.

On 01/27/2026, I received an email from executive director, Maggy Canny, containing the names and phone numbers of direct care staff members who were working the night Resident A passed away.

On 01/27/2026, I attempted phone interviews with direct care staff members Tiara Chapman, Adriyana Cuerton, and Brittany Robbins. Messages were left requesting a return call.

On 01/27/2026, I completed a telephone interview with direct care staff member, Kyle Dixon. Mr. Dixon could not remember the night he worked when Resident A passed away. He does not remember working with Mr. Cade. He stated that with their population, they have many residents pass away.

On 01/30/2026, I completed a telephone interview with direct care staff member, Tiara Chapman. Ms. Chapman has been employed at Addington Place for approximately 26 months. She does not remember working the night Resident A passed away. She did hear about it and stated she was told that Mr. Cade had grabbed Resident A's file after the paramedics arrived and he told them about the do not resuscitate, but they had already begun. She stated they normally have two workers in each building, and each one has their own residents they primarily care for, so Mr. Cade would have been the only one checking on Resident A.

On 01/30/2026, I attempted phone interviews with direct care staff members Adriyana Cuerton and Brittany Robbins. Messages were left requesting a return call.

APPLICABLE RULE	
R 400.671	Resident care.
	(4) A licensee shall provide supervision, protection, and personal care as specified in a resident's assessment plan. A hospice service plan, do-not resuscitate order, or any other advance directive must be included as an addendum to the resident assessment and maintained with the assessment plan in the resident's record.
ANALYSIS:	Based on the information obtained during my investigation, there is enough evidence to support that Resident A was enrolled in a licensed hospice program and had a do not resuscitate order and when he was found unresponsive, the direct care staff member contacted 911 and resuscitation attempts were made. Program director, Kara Fraser, admitted Resident A was in a licensed hospice program and 911 was called instead of the hospice agency. Resident A's documentation indicated that they were to contact the hospice agency if there were issues. Attempts to interview the direct care staff members who were working that night were not successful.
CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION:

Resident A did not receive his comfort medications the night he passed away.

INVESTIGATION:

I initiated the investigation by completing a telephone interview with Relative A1. He took Resident A to Addington Place Clarkston for hospice. Resident A was admitted on 08/29/2025 and Relative A1 received a phone call on 09/02/2025, informing him that Resident A had been found non-responsive that morning and had passed away. He stated Resident A last received his comfort medication (morphine) around 9pm and he had died in the morning.

On 12/08/2025, I completed an unannounced onsite investigation at Addington Place Clarkston. I completed an interview with program director, Kara Fraser. Ms. Fraser did not have a chance to work with Resident A, he was admitted on a Friday, then passed away on Tuesday morning. He was admitted on hospice, after being discharged from a rehabilitation center. He was diagnosed with Alzheimer's and was declining fast. On his day of admission, 08/29/2025, he was lethargic, had a poor appetite, and need total

assistance. He was very sick and weak. He passed away on 09/02/2025. The residents are checked every two hours, but these checks are not documented.

Ms. Fraser provided me with documents from Resident A's file.

When Resident A entered the home, Heart to Heart Hospice prescribed the following medications; lorazepam .5mg, 1 tablet by mouth every four hours as needed, haloperidol 2mg, give .05 ml every four hours, as needed, Levsin .125 mg, give one tablet by mouth every four hours, as needed for secretions, morphine sulfate 20mg, take .25 ml every one hour as needed for pain or shortness of breath, Reglan 10mg, take one tablet every four hours as needed, and acetaminophen 650mg suppository give one rectally every four hours as needed for pain or fever.

I was also provided a form for controlled drugs containing the dates and times Resident A was given his morphine sulfate. He was administered it on 08/29/2025 at 9:15pm and four times on 09/01/2025 at 3:30p, 5:45p, 7p, and 9p.

I reviewed the medication administration record (MAR) for Resident A and the only pain relief medication he received the evening prior to his death was the morphine, with the last being at 9pm.

I attempted to complete a phone interview with Andre Cade on 12/12/2025, 12/15/2025, 12/26/2025, and 01/05/2026. I left messages requesting a return phone call at each attempt. On 12/12/2025 and 12/26/2025, I received a phone call from Mr. Cade and when I answered the phone and identified myself, he disconnected the phone call.

On 01/30/2026, I completed a telephone interview with direct care staff member, Tiara Chapman. Ms. Chapman has been employed at Addington Place for approximately 26 months. She does not remember working the night Resident A passed away. She did hear about it and stated she was told that Mr. Cade had grabbed Resident A's file after the paramedics arrived and he told them about the do not resuscitate, but they had already begun. She stated they normally have two workers in each building, and each one has their own residents they primarily care for, so Mr. Cade would have been the only one checking on Resident A.

On 01/30/2026, I attempted phone interviews with direct care staff members Adriyana Cuerton and Brittany Robbins. Messages were left requesting a return call.

On 02/03/2026, I completed an exit conference, via telephone, with licensee designee, Stephen Levy. The findings were discussed and questions were answered.

APPLICABLE RULE	
R 400.675	Resident medications.
	(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.

ANALYSIS:	Based on the information gathered during the special investigation, there is not enough evidence to support that medication was not given as prescribed, ordered, or directed by an appropriately licensed health care professional. Resident A was prescribed comfort medications, including morphine, to be given as needed. Resident A received his last dose of morphine at 9pm on 09/01/2025 and he was found unresponsive around 5am on 09/02/2025. The direct care staff members check on residents every two hours, but do not document these checks. The direct care staff member who was working would not complete an interview with me and is no longer employed there. The other direct care staff members I was able to interview do not remember Resident A or what happened that evening. There is no evidence to support the fact that Resident A was awake after his last dose of morphine or that he gave any indication he needed the comfort medication.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

I recommend that contingent upon the receipt of an approved corrective action plan, there be no changes made to the license.

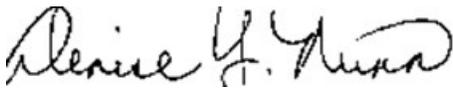


02/03/2026

Sara Shaughnessy
Licensing Consultant

Date

Approved By:



02/24/2026

Denise Y. Nunn
Area Manager

Date