RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

January 24, 2018

Barbara Exel
Addington Place
42010 W Seven Mile Road
Northville, MI 48167

RE: License #: AH820378951
Investigation #: 2017A1013038
Addington Place

Dear Ms. Exel:

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) 975-5053.

Sincerely,

Loma M Campbell, Licensing Staff
Bureau of Community and Health Systems
4th Floor, Suite 4B
51111 Woodward Avenue
Pontiac, MI 48342
(248) 860-3110

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH820378951
Investigation #:	2017A1013038
Complaint Receipt Date:	05/11/2017
Investigation Initiation Date:	05/11/2017
Report Due Date:	07/10/2017
Licensee Name:	ARHC APNVLMI01 TRS, LLC
Licensee Address:	C/O ARC HC Trust ll, Coun 405 Park Ave, 14th Floor New York, NY 10022
Licensee Telephone #:	(212) 415-6551
Administrator:	Barbara Exel
Authorized Representative:	Barbara Exel
Name of Facility:	Addington Place
Facility Address:	42010 W Seven Mile Road Northville, MI 48167
Facility Telephone #:	(248) 305-9600
Original Issuance Date:	02/10/2016
License Status:	TEMPORARY
Effective Date:	02/10/2016
Expiration Date:	08/09/2016
Capacity:	80
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established
A resident's Vicodin went missing.	Yes

III. METHODOLOGY

05/11/2017	Special Investigation Intake 2017A1013038
05/11/2017	Special Investigation Initiated - Telephone Telephoned APS Centralized Intake and made referral
09/01/2017	Inspection Completed On-site
01/22/2018	Contact - Telephone call made Telephoned former staff member Shardana Harris and Lauren Trombley; Left message for Ms. Trombley
01/22/2018	Contact - Document Sent Requested police report
01/22/2018	Contact - Document Received Received police report
01/23/2018	Contact - Telephone call made Telephoned staff member LaKenya Welch
01/24/2018	Exit Conference Conducted with the authorized representative of Addington Place, Barbara Exel, by telephone

ALLEGATION:

A resident's Vicodin went missing.

INVESTIGATION:

On 4/3/17, the facility reported by an incident form dated 4/3/17 the allegation written in this report. The incident report read, "Vicodin delivered 3/21/17 for 6A-2P-10P

scheduled doses- On 4/1/17 6AM unable to be found on med cart. Reported to Zuri Middleton 7A-3P-who contacted Jude Leblanc LPN."

On 9/1/17, I reviewed Resident A's medication orders at the facility. The physician telephone orders signed on 3/21/17 read, "Norco 5/325 q [every] 8 [hours] – Hold for Lethargy". Hydroco/Apap Tab 5-325 [generic name] is equivalent to Norco 5/325 with a brand name of Vicodin.

On 9/1/17, I interviewed administrator Barbara Exel at the facility. Ms. Exel stated that midnight shift nurse Mary McIntyre went to restock medications into the medication cart at 11:00 pm on 3/31/17 and found that the blister packs of Hydroco/Apap Tab 5-325 (hereafter referred to as Vicodin) for Resident A were missing. Ms. Exel stated that Ms. McIntyre had last worked on 3/29/17 and had seen the blister packs labeled for Resident A. Ms. Exel said that staff member Lauren Trombley was the medication passer from 3pm until 11pm on 3/31/17 and had given Resident A the 10:00 pm dose of Vicodin. Ms. Exel stated that staff member Shardana Harris was the medication passer from 7:00 am until 3:00 pm and had given Resident A the 2:00 pm dose of Vicodin. Ms. Exel stated that she notified the Northville Township Police Department on 4/1/17 of the incident and Ms. McIntyre notified day shift nurse Zuri Middleton of the incident on 4/1/17.

On 9/1/17, I interviewed Ms. LeBlanc at the facility. Ms. LeBlanc confirmed that she received a telephone call from Ms. Middleton that there was not sufficient Vicodin available for Resident A. Ms. LeBlanc stated that she asked Ms. Middleton to go through the bin that held medications scheduled to be returned to the pharmacy to see if the Vicodin blister packs had been placed there by mistake. Ms. Middleton informed Ms. LeBlanc that she did not find any Vicodin. Ms. LeBlanc said she spoke to a representative at PharmaScript to ascertain the medication was sent to the facility and tried to contact Ms. Trombley and Ms. Harris to find out if anything suspicious occurred the previous evening.

Ms. LeBlanc said she came into the facility, was able to find one blister pack of Vicodin with 20 pills, found that the two other blister packs of Vicodin were missing, and notified the pharmacy of the situation. Ms. LeBlanc stated that Resident A was scheduled to receive Vicodin three times each day and knew that the pharmacy sent three blister packs of Vicodin on 3/21/17, one for each of the doses of Vicodin 6am, 2pm, and 10pm. Ms. LeBlanc stated that Resident A should have had enough Vicodin available until 4/20/17 because the pharmacy sent a thirty day supply. Resident A was able to receive Vicodin as scheduled on 4/1/17 and the pharmacy delivered additional blister packs of Vicodin on 4/1/17.

On 9/1/17, I reviewed the statements dated 4/1/17 of Ms. Trombley at the facility. Ms. Trombley's statements read "…gave [Resident A] her 9:00 pm meds…am unsure of why it appears that I didn't. As far as the pills being thrown out,…always throw out any left over [sic] pills that are in the med cart not marked "PRN"…don't

think…ever been told to do otherwise…unsure of why the pack was empty…threw everything in the trash bag…took it to the dumpster."

On 9/1/17, I reviewed the Medication Administration Record (MAR) from March 21, 2017 through April 3, 2017 for Hydroco/Apap Tab 5-325 which is equivalent to Norco 5/325mg (aka Vicodin). The staff initials for the 10:00 pm dose of Vicodin on 3/31/17 were not entered at the time the medication was administered

On 1/19/18, I interviewed Ms. Middleton by telephone. Ms. Middleton confirmed that Ms. McIntyre reported that the count for Resident A's Vicodin was "off" and there was a discrepancy with the amount of Vicodin on hand for Resident A versus the amount listed on the pharmacy sheet on 4/1/17. Ms. Middleton said after receiving this information she notified wellness nurse Jude LeBlanc.

On 1/23/18, I interviewed staff member LaKenya Welch by telephone. Ms. Welch stated that she administered Resident A's 6:00 am dose of Vicodin and there was sufficient pills in the blister pack for all the other doses.

On 1/22/18, I interviewed Ms. Harris by telephone. Ms. Harris stated that she had no knowledge of what happened to Resident A's Vicodin and claimed Resident A's Vicodin was in the medication cart when she left at 3:00 pm on 3/31/17.

On 1/22/18, I attempted to contact Ms. Trombley by telephone. Ms. Trombley did not answer or respond to the telephone calls and messages left at the telephone number provided by the facility.

On 1/22/18, I reviewed the Northville Township Police Department report received via fax. The report indicated that on 4/21/17 the two blister packs were delivered to the Michigan State Crime Lab in Northville for latent print analysis with the elimination fingerprints obtained and on 6/27/17 the results were received from the lab with no suspects identified closing the case because of "no viable investigative leads".

Ms. Exel stated that Ms. Trombley's and Ms. Harris' employment at Addington Place was suspended pending an investigation of the incident. Ms. Exel reviewed the medication training procedure at Addington Place at the time of the incident. Ms. Exel said the procedure at the time of the incident on 4/1/17 concerning narcotic medications such as Vicodin was that the medication was to be left in the medication cart because only a thirty day supply of the medication was provided by the pharmacy. However, since this incident, Ms. Exel said the procedure has changed in that all blister pack of medication has to be returned to the nursing station for disposal by the pharmacy. In addition, counting as well as signing off on the counting of narcotic medications are being completed by the nurse and medication passer at the end of each shift; the medication has to initialed as well as dated in the area where the pill was taken; the medications are stored in a locked box on the

medication cart; and the keys to the medication cart are being returned to the nurse after each shift.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(3) If a home or the home's administrator or direct care staff member supervises the taking of medication by a resident, then the home shall comply with all of the following provisions: (v) The initials of the person who administered the medication, which shall be entered at the time the medication is given.
ANALYSIS:	The initials of the staff member that administered Resident A's Vicodin at 10:00 pm on 3/31/17 were not entered at the time that the medication was administered.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(5) A home shall take reasonable precautions to ensure or assure that prescription medication is not used by a person other than the resident for whom the medication is prescribed.
ANALYSIS:	On 4/1/17, the home did not have an organized plan or reasonable measures in place to ensure that prescription medications were handled appropriately. Ms. Trombley stated that she discarded the medication and a check by another personnel was not done to ensure that the medication was not discarded although the medications was still needed by Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 1/24/18, I conducted an exit conference with the authorized representative of Addington Place, Barbara Exel, by telephone.

IV. RECOMMENDATION

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

1/24/2018

Loma M Campbell — Date
Licensing Staff

Approved By:

1/24/18

Russell B. Misiak — Date
Area Manager