



RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

March 15, 2018

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

RE: License #: AH820378951
Investigation #: 2018A1013017
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,

A handwritten signature in black ink that reads "Loma M Campbell". The signature is written in a cursive style with a large, stylized initial "L".

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
THIS REPORT CONTAINS QUOTED PROFANITY**

I. IDENTIFYING INFORMATION

License #:	AH820378951
Investigation #:	2018A1013017
Complaint Receipt Date:	12/19/2017
Investigation Initiation Date:	12/19/2017
Report Due Date:	02/18/2018
Licensee Name:	ARHC APNVLMI01 TRS, LLC
Licensee Address:	C/O ARC HC Trust II, 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
On December 8, 2017, one of the two of the caregivers hit a resident in the face with a towel and both caregivers are being charged with assault and battery.	Yes

III. METHODOLOGY

12/19/2017	Special Investigation Intake 2018A1013017
12/19/2017	Special Investigation Initiated - Telephone Telephoned complainant
12/19/2017	APS Referral Telephoned DHHS Centralized Intake to make a referral
12/28/2017	Inspection Completed On-site On-site inspection included reviewing of records, interviewing of staff and residents, and observing the environment.
12/28/2017	Contact - Document Received Received police reports from facility
12/28/2017	Contact - Telephone call made Telephoned Mary McIntyre; left message
12/28/2017	Contact - Telephone call made Telephoned Gloria Walker
01/22/2018	Contact - Telephone call made Telephoned Mykeetah Stromer
03/12/2018	Exit Conference Conducted with the authorized representative of Addington Place, Barbara Exel, by telephone

ALLEGATION:

On December 8, 2017, one of the two of the caregivers hit a resident in the face with a towel and both caregivers are being charged with assault and battery.

INVESTIGATION:

On 12/19/17, the department received the allegation written in this report.

On 12/19/17, I made a referral to the Department of Health and Human Services Central Intake.

On 1/02/18, I received a letter from Adult Protectives Services acknowledging the receipt of the referral and indicating that the referral was not assigned for investigation.

On 12/19/17, I interviewed Complainant 1 and Complainant 2 by telephone. I originally telephoned Complainant 1 and while speaking to Complainant 1, Complainant 1 asked Complainant 2 to talk to me on the telephone. Complainant 1 stated that a camera was installed in Resident A's room by Resident A's family to ensure that Resident A was receiving proper care. Complainant 1 and Complainant 2 both stated that on 12/8/17, Resident A's family members observed from the camera placed in Resident A's room that staff members MyKeetah Stromer and Gloria Walker had verbally abused Resident A. Complainant 1 and Complainant 2 said the family members heard Ms. Walker swearing at Resident A by saying "if you walk I am not going to catch you". In addition, Complainant 1 and Complainant 2 stated that the family members observed Ms. Walker hit Resident B (a resident who had wandered into Resident A's room) with a towel. Complainant 1 and Complainant 2 stated that the incidents concerning Resident A and Resident B were reported to the Northville Township Police Department and the facility subsequently terminated both Ms. Stromer's as well as Ms. Walker's employment at Addington Place. Complainant 1 and Complainant 2 also stated that on 11/7/17, Ms. Stromer purposely pushed Resident A onto the bed while getting Resident A ready for bed.

On 12/28/17, I reviewed Resident A's and Resident B's record at the facility. Resident A moved to Addington Place on 5/9/17 with a diagnosis of vascular dementia.

Resident B moved to Addington Place on 5/27/16 with a diagnosis of dementia.

Resident A's service plan dated 5/9/17 contained behavioral interventions as well the use of PRN (as needed) medication to address anxiety/nervousness.

Resident B's service plan dated 6/11/17 read "Expresses anxiety/agitation by: crying and getting aggitated [sic]" and contained behavioral interventions to address crying spells and agitation.

On 12/10/2017, the department received a telephone call from Jude LeBlanc concerning the incident described by the complainant. In addition, a written incident report concerning the incident was received in a timely manner.

On 12/28/17, I interviewed wellness nurse Jude LeBlanc at the facility. Ms. LeBlanc stated that she received a telephone call from midnight nurse Mary McIntyre at about 10:15 pm on 12/9/17 reporting that a Northville Township police officer was at the facility investigating a case of abuse that had been reported to the Northville Township Police Department. Ms. LeBlanc said she arrived at the facility at about 10:45 pm and the police officer had staff member Gloria Walker and Ms. McIntyre in the office. Ms. LeBlanc said the police officer reported that Resident A's family had placed a camera in Resident A's room, reviewed the videotape footage on 12/8/17, and took the videotape footage to the Northville Township Police Department. Ms. LeBlanc stated that she did not see the entire videotape footage and the police officer showed her a part of the videotape wanting to know the staff members who had been in Resident A's room. Ms. LeBlanc stated that she identified Ms. Walker from the videotape but could not positively identify the other staff member because all that was shown was the back of the employee. Ms. LeBlanc said the police officer relayed that the videotape footage had been reviewed and it was observed that the staff members were swearing at Resident A as well as one of the staff member was snapping a towel in Resident A's face. Ms. LeBlanc said she saw on the videotape where Resident B entered Resident A's room and the staff members told Resident B to leave the room and to shut the door.

On 12/28/17, I interviewed Regional Support Person for Addington Place Sheri Emery at the facility. Ms. Emery stated that she had not seen the videotape referenced by the police officer, Complainant 1, and Complainant 2 because the videotape had been provided to the Northville Township Police Department. Ms. Emery confirmed that a police officer was at Addington Place on 12/9/17 and the police officer shared verbally the content contained on the videotape with her. Ms. Emery stated that Resident A's room door was closed when Ms. Stromer and Ms. Walker were assisting Resident A so the camera installed by Addington Place in the Addington Place hallway could not see what was occurring in Resident A's room. From the camera installed in the hallway by Addington Place, Ms. Emery stated that Resident B could be seen walking into Resident A's room while Ms. Stromer and Ms. Walker were assisting Resident A. Ms. Emery stated that Ms. Stromer and Ms. Walker were arraigned on 12/11/17, charged with misdemeanor assault and battery, and released on personal bond on 12/11/17. Ms. Emery said Ms. Stromer's and Ms. Walker's employment at Addington Place was terminated on 12/11/17.

On 1/22/18, I interviewed Ms. Stromer by telephone. Ms. Stromer stated that on 12/8/17 Resident A exhibited behaviors of hitting other residents, tearing pictures off the wall, saying that she was being beaten, and pulling/grabbing Resident B's arm. Ms. Stromer said Resident B's gait was unsteady and Resident A was grabbing onto Resident B's walker which could have caused Resident B to fall. Ms. Stromer said Resident A shuffled her feet and she said to Resident A to stop before you fall. Ms.

Stromer said she and Ms. Walker escorted Resident A to her room by each having an arm of Resident A walking her to the room. As she and Ms. Walker entered Resident A's room, Ms. Stromer stated Resident A's knee buckled with Resident A attempting to go down to the floor. Ms. Stromer said she then said to Resident A you have to stop that because "if you fall I cannot pick you up" and Resident A stopped trying to fall and stood straight. Ms. Stromer said she walked over to the recliner chair, saw a night gown, picked up the gown from the recliner chair, and she and Ms. Walker walked Resident A into the bathroom. Ms. Stromer said she heard Resident A's room door open and saw that it was Resident B. Ms. Stromer said she placed Resident A on the toilet, began removing Resident A's clothing while Ms. Walker stepped out of the bathroom to escort Resident B out of Resident A's room. Ms. Stromer said Ms. Walker then returned to Resident A's room to assist her in getting Resident A ready for bed. Ms. Stromer said she got Resident A off the toilet, walked Resident A out of the bathroom, directed Resident A to the bed, and put Resident A to bed. After putting Resident A into bed, Ms. Stromer stated that she and Ms. Walker walked out of Resident A's room. Ms. Stromer said she did not observe Ms. Walker with a towel and did not see Ms. Walker hit Resident B with a towel. Ms. Stromer denied shoving Resident A and felt that three staff members should have working with Resident A because of Resident A's behaviors.

On 12/28/17, I interviewed Ms. Walker by telephone. Ms. Walker stated that she was on the telephone talking to her Goddaughter's grandmother when Ms. Stromer asked her to assist with the care of Resident A. Ms. Walker said she was saying to the individual on the telephone "you need to start whopping her ass" referring to her Goddaughter and denied swearing at Resident A or snapping a towel at Resident B.

The Northville Township Police Department report dated 12/9/17 read "The individual Ms. LeBlanc identified as WALKER was the individual who was scene [sic] on video whipping the towel/in around [Resident B's] face. The Northville Township Police report also read "Security Video Footage from 11/07/17...observed Mykeetah push [redacted name] from behind, with her left arm, onto her bed..."

The Northville Township Police Department report confirmed that MyKeetah Stromer and Gloria Walker were arraigned in 35th District Court on 12/11/17 on a charge of misdemeanor Assault and Battery with a court date scheduled for 8:30 am on 1/5/18.

APPLICABLE RULE	
MCL 333.20201	Policy describing rights and responsibilities of patients or residents;
	(1) A health facility or agency that provides services directly to patients or residents and is licensed under this article shall adopt a policy describing the rights and responsibilities of patients or residents admitted to the health facility or agency.

	<p>Except for a licensed health maintenance organization which shall comply with chapter 35 of the insurance code of 1956, 1956 PA 218, MCL 500.3501 to 500.3580, the policy shall be posted at a public place in the health facility or agency and shall be provided to each member of the health facility or agency staff. Patients or residents shall be treated in accordance with the policy.</p>
<p>For Reference: MCL 333.20201</p>	<p>2(e) A patient or resident is entitled to receive adequate and appropriate care, and to receive, from the appropriate individual within the health facility or agency, information about his or her medical condition, proposed course of treatment, and prospects for recovery, in terms that the patient or resident can understand, unless medically contraindicated as documented in the medical record by the attending physician or a physician's assistant to whom the physician has delegated the performance of medical care services.</p> <p>2(l) A patient or resident is entitled to be free from mental and physical abuse and from physical and chemical restraints, except those restraints authorized in writing by the attending physician or a physician's assistant to whom the physician has delegated the performance of medical care services for a specified and limited time or as are necessitated by an emergency to protect the patient or resident from injury to self or others, in which case the restraint may only be applied by a qualified professional who shall set forth in writing the circumstances requiring the use of restraints and who shall promptly report the action to the attending physician or physician's assistant. In case of a chemical restraint, a physician shall be consulted within 24 hours after the commencement of the chemical restraint.</p>
<p>ANALYSIS:</p>	<p>Ms. Walker's statements made while assisting Resident A on 12/8/17 were not appropriate. In addition, the videotape described by the complainant and observed by the police officer showed that Ms. Walker was "whipping a towel/in around" Resident B's face and another tape showed that Ms. Stromer had pushed Resident A into bed on 11/7/17. The staff involved in these events did not ensure the provision of adequate and appropriate care and protection from abuse.</p>
<p>CONCLUSION:</p>	<p>VIOLATION ESTABLISHED</p>

On 3/12/18, I conducted an exit conference with the authorized representative of Addington Place, Barbara Exel by telephone. Ms. Exel stated that she was appalled and saddened at what happened to Resident A and Resident B, have had one to one meetings with staff members to address issues of stress and frustration, and has established a protocol for staff members to contact as well as meet with a social worker to get tools on how to handle frustration and to decrease stress.

IV. RECOMMENDATION

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

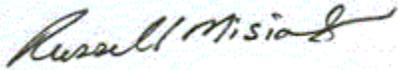


3/15/2018

Loma M Campbell
Licensing Staff

Date

Approved By:



3/15/18

Russell B. Misiak
Area Manager

Date