GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 29, 2019

Addington Place
Sheri Emery
42010 W Seven Mile Road
Northville, MI 48167

RE: License #: AH820378951
Investigation #: **2019A1022005**
Addington Place

Dear Ms. Emery:

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.

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 (616) 356-0100.

Sincerely,

Barbara Zabitz, Licensing Staff
Bureau of Community and Health Systems
350 Ottawa, N.W. Unit 13, 7th Floor
Grand Rapids, MI 49503
(313) 296-5731

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH820378951
Investigation #:	2019A1022005
Complaint Receipt Date:	05/01/2019
Investigation Initiation Date:	05/06/2019
Report Due Date:	06/31/2019
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/ Authorized Representative:	Sheri Emery
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:	REGULAR
Effective Date:	08/10/2017
Expiration Date:	08/09/2018
Capacity:	80
Program Type:	AGED ALZHEIMERS

ALLEGATION:

	Violation Established?
After a resident had a fall, the facility took no actions to prevent further falls. These further falls resulted in serious injury to the resident.	Yes
The facility did not report the falls to the department.	No
Additional Findings	No

II. METHODOLOGY

05/01/2019	Special Investigation Intake 2019A1022005
05/06/2019	Special Investigation Initiated - Telephone Phone call to complainant.
05/16/2019	Inspection Completed On-site
05/16/2019	Inspection Completed-BCAL Sub. Compliance
05/17/2019	APS Referral

ALLEGATION:

After a resident had a fall, the facility took no actions to prevent further falls. These further falls resulted in serious injury to the resident.

INVESTIGATION:

On 5/1/19, the complainant contacted the department by email, alleging that her mother had sustained serious injury arising from several falls that took place in the facility.

On 5/6/19, I interviewed the complainant by telephone. According to the complainant. Resident A had been admitted to the facility in January 2019 without a

history of falls. The complainant stated that although Resident A was confused, she was physically independent for all activities of daily living at the time.

On 3/17/19, at 5:00 a.m., Resident A fell. According to the complainant, Resident A was seated in the common area of the Bradford unit in the presence of staff, and when she got up from the chair, she lost her balance and fell, hitting the back of her head on the floor. Emergency responders were called, but assessed Resident A as not needing further treatment other than “close monitoring.”

The complainant went on to say that on the next day, 3/18/19, at 7:00 p.m., Resident A was found in bathroom on floor with a laceration on above right eyebrow. Resident A required hospitalization to treat the laceration as well as treatment for two spine fractures.

According to the complainant, Resident A returned to the facility at the beginning of April 2019. The complainant stated that a private duty caregiver was hired to attend Resident A from 7:00 p.m. to 7:00 a.m. daily. Additionally, according to the complainant, the facility was to ensure that she sat in a wheelchair, with an alarm when out of bed. The complainant went on to say that she went to visit Resident A on 4/9/19 and found Resident A sitting on a couch in another’s resident’s room, without the wheelchair and no evidence that the alarm had sounded.

Resident A fell a third time. The complainant stated that on the morning of 4/11/19, Resident A was found on the floor at the entrance of her room. As a result of this fall, the resident had broken her hip and sustained a closed head injury.

On 5/17/19, I notified adult protective services of the complainant’s concerns.

On 5/16/19, I interviewed administrator Ashley Dubay and director of nursing Jude Leblanc in the facility. Ms. Dubay stated that Resident A was not considered to be at risk for falls until 3/17/19. Ms. Dubay and I then reviewed Resident A’s progress notes. For the fall that occurred on 3/17/19, the nurse’s documentation described the fall and ended the narrative with “will continue to monitor.” I asked Ms. Dubay if information about Resident A’s fall had been passed along from outgoing to incoming nurse at change-of-shift and documented on the facility’s *Nurse-to-Nurse* report, but no documentation was found. Ms. Dubay was asked if Resident A’s fall had been discussed at the facility’s daily morning meeting, held on Monday, 3/18/19, but no documentation was found for this either. Both Ms. Dubay and Ms. LeBlanc agreed that as of 3/17/19, facility staff were not concerned about Resident A’s fall risk, as she was able to ambulate using only a walker for assistance. However, on 3/18/19 at 7:30 p.m., Resident A was found face down, on the bathroom floor, bleeding from a laceration on her forehead. Resident A was sent out to a local hospital and was admitted for treatment.

Resident A returned to the facility and her service plan was updated on 4/2/19. According to the service plan, Resident A was ambulatory with a walker with stand-

by assistance but was to have both a bed and a chair alarm, as well as a hospital bed with a concave mattress. According to the service plan, she needed the physical assistance of one person for all transfers.

Ms. Dubay and Ms. LeBlanc were asked about the incident described by the complainant as occurring on the Tuesday after Resident A returned from the local hospital, 4/9/19. Ms. Dubay stated that she clearly recollected the incident because the complainant had come straight to her office after finding Resident A in the bedroom across the hall from her own. According to Ms. Dubay, when she went to investigate, she found Resident A's wheelchair and alarm in Resident A's bedroom. Ms. Dubay stated that she assumed Resident A had been in her own room when she removed the alarm, stood up by herself, and ambulated across the hall. When asked if caregivers were notified that Resident A was able to remove the alarm, stand up from her wheelchair and independently ambulate, Ms. Dubay indicated that she did not pass this information along to staff. Ms. Dubay stated that the expectation was that staff would keep Resident A in the common room of the unit, where she could be supervised.

Ms. Dubay and Ms. LeBlanc were asked about Resident A's third fall that occurred on 4/11/19. According to the *Incident Report*, at 9:10 a.m., Resident A was found on the floor, outside of her room. Ms. Dubay stated that Resident A must have been in her room, removed the alarm, stood up and ambulated to the doorway of her room when she fell. Ms. Dubay went on to say that Resident A fractured her left femur in the fall and had not returned to the facility.

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(5) A home shall update each resident's service plan at least annually or if there is a significant change in the resident's care needs. Changes shall be communicated to the resident and his or her authorized representative, if any.
For Reference: R325.1901	**Definitions.**
	(21) "Service plan" means a written statement prepared by the home in cooperation with a resident and/or the resident's authorized representative or agency responsible for a resident's placement, if any, and that identifies the specific care and maintenance, services, and resident activities appropriate for each individual resident's physical, social, and behavioral needs and well-being and the methods of providing the care and services while taking into account the preferences and competency of the resident.

ANALYSIS:	Although the facility addressed Resident A's fall risk in her service plan, the facility did not recognize that Resident A had the ability to remove the alarm and stand from her wheelchair, thus rendering the plan ineffective as an intervention to prevent falls. The plan lacked staff instruction related to the resident's specific supervision need related to her demonstrated ability to remove alarming devices.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The facility did not report the falls to the department.

INVESTIGATION:

On 5/16/19, I asked Ms. Dubay to provide the *Incident Reports* corresponding to the falls described by the complainant. According to the complainant, Resident A fell on 3/17/19, 3/18/19, and 4/11/19. Ms. Dubay produced the three *Incident Reports* that corresponded to those dates.

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, accidents, elopement.**
	(3) The home shall report an incident/accident to the department within 48 hours of the occurrence. The incident or accident shall be immediately reported verbally or in writing to the resident's authorized representative, if any, and the resident's physician.
ANALYSIS:	There was no evidence that the facility did not report in the proper manner.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

III. RECOMMENDATION

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

Barbara Zabitz
Licensing Staff

Date

Approved By:

Russell Misiak

5/29/19

Russell B. Misiak
Area Manager

Date