GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 29, 2021

Nathan Boyle
Addington Place
42010 W Seven Mile Road
Northville, MI 48167

RE: License #: AH820378951
Investigation #: 2022A0784002
Addington Place

Dear Mr. Boyle:

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.

Sincerely,

Aaron L Clum

Aaron Clum, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 230-2778

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH820378951
Investigation #:	2022A0784002
Complaint Receipt Date:	10/11/2021
Investigation Initiation Date:	10/11/2021
Report Due Date:	12/10/2021
Licensee Name:	ARHC APNVLMI01 TRS, LLC
Licensee Address:	c/o Healthcare Trust, Inc 650 Fifth Ave New York, NY 10019
Licensee Telephone #:	(212) 415-6551
Administrator:	Dana Daunter
Authorized Representative:	Nathan Boyle
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:	08/10/2021
Expiration Date:	08/09/2022
Capacity:	80
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A was mistreated by staff	Yes
Additional Findings	No

III. METHODOLOGY

10/11/2021	Special Investigation Intake 2022A0784002
10/11/2021	Special Investigation Initiated - Telephone Interview with authorized representative Nathan Boyle
10/11/2021	Contact - Telephone call made Attempted with administrator Dana Daunter. Message left requesting a return call
10/11/2021	Contact - Document Sent Special Investigation document/info request made by email to admin and AR
10/13/2021	Contact - Document Received Investigative documents recieved by email
10/15/2021	Contact - Telephone call made Interview with Ms. Daunter
10/29/2021	Exit Conference – Telephone Conducted with authorized representative Nathan Boyle.

ALLEGATION:

Resident A was mistreated by staff

INVESTIGATION:

On 10/11/21, the department received this complaint from adult protective services (APS) centralized intake.

According to the complaint, on 10/10/21, at approximately 5:48am, associate Terrance James was verbally abusive and aggressive with Resident A. While trying to wake Resident A up, Mr. James spoke loudly while pulling Resident A's sheets and blankets off his bed aggressively. Mr. James touched Resident A with a "little

push” to wake him up. Resident A called Mr. James an “asshole” and Mr. James responded by calling Resident A an “asshole” back multiple time. Resident A was not injured related to this interaction.

Review of the facility licensing file revealed a timely report was submitted to the department regarding Resident A with details consistent with those provided in the complaint. The report indicated Mr. James was suspended pending an investigation with possible termination.

On 10/15/21, Interviewed administrator Dana Daunter by telephone. Ms. Daunter stated the facility was notified of the incident between Resident A and associate Terrance James on 10/10/21 by Resident A’s authorized representative (Resident AR). Ms. Daunter stated Resident A has a video camera in his room and the incident was observed by Resident AR from the video footage. Ms. Daunter stated she also viewed the footage confirming the inappropriate treatment by Mr. James. Ms. Daunter stated Mr. James was a new employee but had been provided training regarding resident rights prior to working with residents and that he should have been well aware that the manner in which he addressed Resident A was inappropriate. Ms. Daunter stated she spoke to Mr. James by telephone today, 10/15, for the first time since the incident since he had not worked a shift since then and she was unable to reach him by phone prior to today after several attempts to do so. Ms. Daunter stated she officially terminated Mr. James during the call and that Mr. James offered no defense of his actions reportedly saying “I figured this would happen” in regard to him being terminated. Ms. Daunter stated that to her knowledge, Mr. James does not hold a license of any kind as he did not provide one during his hiring process. Ms. Daunter stated the facility was aware of the video footage. Ms. Daunter stated there were no other witnesses to the incident.

I reviewed the video footage of the incident, provided by Ms. Daunter, which Ms. Daunter identified the staff member as being Mr. James. The video was 2 min and 6 secs long and included audio. In the footage, Mr. James can be seen walking into Resident A’s room, switching the light on and announcing several times “it’s time to get up”. After several seconds Mr. James appears to be irritated that Resident A is not getting up and proceeds to pull Resident A’s blanket off of him. Resident A can be heard saying what sounded like “why are you an asshole today” to which Mr. James replies says Resident A is being the “asshole”. Mr. James continues to tell Resident A “it’s time to get up” in an increasingly loud and aggressive tone. Mr. James appears to lightly tap Resident A on the shoulder as if to somehow encourage him or motivate him to get up. Resident A is heard calling Mr. James an “asshole” once again with Mr. James again responding in kind. Mr. James continues to tell Resident A he needs to get up until the video ends.

I reviewed a document titled *Resident Rights Employee Acknowledgement*, provided by Ms. Daunter which included the resident rights as outlined in the public health

code. The last page of the document includes Mr. James written name and signature and is dated 9/28/21.

I reviewed Mr. James training transcript provided by Ms. Daunter. The transcript indicated Mr. James had completed courses titled *Assisting Residents with Activities of Daily Living*, on 9/29/21, *Essentials of Resident Rights*, on 10/1/21, and *Preventing, Recognizing, and Reporting Abuse*, on 9/30/21. The transcript further indicated Mr. James was tested on his knowledge of each coarse and had successfully passed.

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. 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.
For Reference MCL 333.20201	**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, by a physician's assistant with whom the physician has a practice agreement, or by an advanced practice registered nurse, 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, physician's assistant, or advanced practice registered nurse who authorized the restraint. In case of a chemical restraint, the physician, or the advanced practice registered nurse who authorized the restraint, shall be consulted within 24 hours after the commencement of the chemical restraint.**

ANALYSIS:	The communication with use of inappropriate language and actions by Mr. James to Resident A did not reflect a dignified provision of care. While the investigation revealed that administration took appropriate action in terminating Mr. James employment upon obtaining knowledge and evidence of his actions, Mr. James actions ultimately represent a violation of the intent of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 10/29/21, I discussed the findings of the investigation with authorized representative Nathan Boyle.

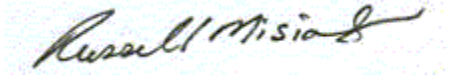
IV. RECOMMENDATION

Upon receipt of acceptable corrective action plan, it is recommended that the status of the license remain unchanged.

10/26/21

Aaron Clum — Date
Licensing Staff

Approved By:



10/28/21

Russell B. Misiak — Date
Area Manager