GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 21, 2022

Stephen Levy
Addington Place of Northville
42010 W Seven Mile Road
Northville, MI 48167

RE: License #: AH820378951
Investigation #: 2022A1027082
Addington Place of Northville

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed by the authorized representative and dated.

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. 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 (517) 241-1970.

Sincerely,

Jessica Rogers

Jessica Rogers, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 285-7433

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH820378951
Investigation #:	2022A1027082
Complaint Receipt Date:	08/10/2022
Investigation Initiation Date:	08/11/2022
Report Due Date:	10/09/2022
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:	Tyler May
Authorized Representative:	Stephen Levy
Name of Facility:	Addington Place of Northville
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:	08/10/2022
Expiration Date:	08/09/2023
Capacity:	80
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A had not received her medications as prescribed.	Yes
Residents' dining tables and placements were not cleaned and disinfected after activities. Resident A's room was not cleaned.	No
Weekly menus were not posted.	Yes
The facility was not accommodating Resident A's requests.	No
Resident units lacked cleaning supplies.	No
The facility lacked paper towels and soap at dining room sink.	No
The facility lacked sufficient supply of COVID personal protective equipment. The facility lacked always locking the front entrance door.	No
Resident A's service plan was not updated.	No
Resident A's hands were not washed before meals with either soap or hand sanitizer. Resident A's brief was not changed. Resident A's ted hose stockings were not checked by staff. Resident A had two incidents at the facility.	No
The facility has one medication technician for three units.	No
Additional Findings	No

The complainant identified some concerns that were not related to licensing rules and statues for a home for the aged. Therefore, only specific items pertaining to homes of the aged provisions of care were considered for investigation. The following items were that that could be considered under the scope of licensing.

III. METHODOLOGY

08/10/2022	Special Investigation Intake 2022A1027082
08/11/2022	Special Investigation Initiated - Letter Email sent to administrator Tyler May requesting an employee list

08/11/2022	Contact - Document Received Email received with requested documentation
08/15/2022	Contact - Document Sent Email sent to complainant requesting additional information
08/16/2022	Contact - Document Received Email received from complainant with requested information
08/16/2022	Contact - Telephone call received Voicemail received from complainant
08/16/2022	Contact - Telephone call made Voicemail left with complainant
08/17/2022	Contact - Telephone call made Telephone interview conducted with complainant
08/17/2022	Contact - Document Received Email received from complainant with additional information
08/19/2022	Contact - Document Received Email received from complainant with additional information
08/22/2022	Inspection Completed On-site
08/22/2022	Contact - Telephone call made Telephone interview conducted with Employee #6
08/23/2022	Contact - Document Received Requested documentation provided by Mr. May
09/19/2022	Contact - Document Sent Two separate emails sent to Mr. May requesting additional information/documentation
09/19/2022	Contact - Document Received Email received from Mr. May with part of requested information/documentation
09/19/2022	Contact - Document Received Email received from Employee #2 with requested information and informing the department additional documentation will be emailed tomorrow.

09/20/2022	Contact - Document Received Email received from Employee #2 with requested documentation
09/21/2022	Contact - Telephone call made Telephone interview conducted with Employee #2
09/21/2022	Contact - Document Received Email received from Employee #2 with requested documentation
09/21/2022	Inspection Completed-BCAL Sub. Compliance
11/16/2022	Exit Conference Conducted with authorized representative Stephen Levy by voicemail

ALLEGATION:

Resident A had not received her medications as prescribed.

INVESTIGATION:

On 8/10/2022, the department received a complaint submitted to the online complaint system which read Resident A had not been prescribed her medications for constipation Metamucil and Miralax. Additional allegations received by email from the complainant read Resident A was diagnosed with Laryngopharyngeal reflux in which she had been prescribed Prilosec upon admission to the facility but had not received it. The complaint read family received a new prescription Prilosec in which was given to the facility nurse on 6/13/2022. The complaint read family purchased a 14-day supply of Prilosec on 6/16/2022 and provided it to the facility since it had not been delivered yet. The complaint read on 6/27/2202, Resident A's family was informed the prescription for Prilosec needed to be signed by the physician. The complaint read on 6/29/2022, the facility nurse informed the Resident A's family there were nine remaining doses of the Prilosec in which there should have been no remaining doses as of that date. The complaint read on 6/30/2022, Resident A's family provided the signed Prilosec prescription to the facility medication technician and on 7/1/2022, it was delivered to the facility awaiting to be entered into the medication administration record (MAR) by the facility nurse. The additional allegations read on 5/19/2022, an order for Biofreeze was on Resident A's pharmacy invoice in which arrived at the facility three months later on 8/11/2022. The complaint read Resident A had an order to crush allowable medications in apple sauce or pudding. The complaint read Resident A was prescribed Paxlovid for a diagnosis of COVID on 7/1/2022 in which the instructions for administration read to swallow the tablets whole, and do not chew, break, or crush. The additional allegations read staff were crushing Paxlovid. The additional allegations read staff entered Resident A's

Colace (Docusate Sodium) medication to be given as a gel capsule instead of a crushable pill.

Additionally, the complaint read there was one medication technician for two units on 8/15/2022 who attempted to administer Resident A's 8:00 PM medications at 9:45 PM however they were not given because she was sleeping.

On 8/22/2022, I conducted an on-site inspection at the facility. I conducted an interview with administrator Tyler May who stated the facility had switched medication administration systems in June 2022. Mr. May stated he could provide medication pass reports for January through mid-June 2022 and the MARs for mid-June through August 2022.

While on-site, I interviewed Employee #1 who stated residents and/or their family would provide a medication prescription(s) signed by their physician in which was faxed to MedExpress pharmacy. Employee #1 stated the pharmacy entered the medications into their electronic system and shipped them to the facility. Employee #1 stated Employee #2 verified the medication order was entered correctly by the pharmacy, then the medications were placed in the medication cart for administration to the resident.

While on-site, I interviewed Employee #3 whose statements were consistent with Employee #1. Employee #3 stated Resident A's medications were administered as prescribed.

While on-site, I reviewed Resident A's current medication list with Employee #3 in which I observed the medications in the medication cart corresponded with her medication list and there was sufficient supply of each.

I reviewed Resident A's face sheet in which read she was admitted to the facility on 7/27/2020 and the diagnoses listed read consistent with the complaint.

I reviewed Resident A's service plan which read she required total assistance for all aspects of medication management.

I reviewed Resident A's physician orders for medications. Order dated 1/5/2022 read give meds whole in juice or may crush allowable meds and give in food or liquid. The orders read the following medications were ordered and dated: Polyethylene Glycol (Miralax) 2/9/2022, Metamucil 5/23/2022, Omeprazole (Prilosec) 7/3/2022, Biofreeze and Docusate Sodium 8/8/2022. The Paxlovid order read *3 Tablet Therapy Pack by mouth Two times per day every day at 8:00 AM, 8:00 PM* in which was prescribed for 5 days starting 7/1/2022.

I reviewed Resident A's medication pass reports from January 1, 2022, through June 21, 2022, as well as her MARs from June 22, 2022, through August 21, 2022, which read:

Metamucil:
The February 2022 medication pass report read Metamucil was administered on 2/19/2022 through 2/28/2022.
The March 2022 medication pass report read staff were waiting for delivery of Metamucil from the pharmacy on 3/10/2022 and 3/28/2022. The March 2022 medication pass report read on 3/19/2022 and 3/20/2022, the medication was not administered.
The April 2022 medication pass report read Metamucil was not administered on 4/2/2022 and was not in the cart on 4/3/2022.
The May 2022 medication pass report read Resident A refused Metamucil on 5/18/2022.
The June 2022 medication pass report read Resident A was not administered Metamucil on 6/8/2022. The June 2022 MARs from 6/22/2022 through 6/30/2022 read she received Metamucil as prescribed.
The July and August 2022 MARs read Metamucil was administered as prescribed.

Polyethylene Glycol (Miralax):
The January, February, March, and April 2022 medication pass reports read Miralax was administered as prescribed.
The May 2022 medication pass report read Resident A refused the Miralax on 5/18/2022.
The June 2022 medication pass report read Resident A was not administered Miralax on 6/8/2022. The June 2022 MARs read Resident A received Miralax as prescribed from 6/22/2022 through 6/30/2022.
The July and August 2022 MARs read Miralax was administered as prescribed.

Omeprazole (Prilosec):
The June 2022 medication pass report read Prilosec was not administered on 6/16/2022 and 6/17/2022. The June MAR read Prilosec was administered from 6/22/2022 through 6/30/2022.
The July 2022 MAR read Prilosec started on 7/4/2022 and administered as prescribed.
The August 2022 MAR read Prilosec was administered as prescribed.

Biofreeze:
The May 2022 medication pass report read on 5/6/2022 at 4:41 PM Biofreeze was not in the cart and on 5/11/2022 at 11:11 AM, it read Resident A refused application of Biofreeze.
The June 2022 medication pass report read Biofreeze was applied as prescribed.
The June 2022 MAR read Biofreeze was applied as prescribed from 6/22/2022 through 6/30/2022.
The July 2022 MAR read Biofreeze was applied as prescribed, except on 7/30/2022 for both the 8:00 AM and 4:00 PM doses, staff noted the medication was not administered because they were waiting for pharmacy.

The August 2022 MAR read Biofreeze was applied as prescribed except for the evening doses on 8/8/2022, 8/9/2022 and 8/14/2022 in which staff noted the medication was not administered because it was not in the medication cart.

Paxlovid:
The July 2022 MAR read Paxlovid was administered as prescribed.

Docusate Sodium:
The January through April 2022 medication pass report read Resident A was administered Docusate Sodium tablets as prescribed.
The May through August 2022 medication pass reports/MARs read Resident A was administered Docusate Sodium capsules, then tablets were ordered on 8/8/2022 and administered as prescribed.

I reviewed the facility's medication policy which in part read all medication/treatment orders shall be in writing and include a physician signature. The policy in part read each dose administered is properly recorded in the MAR/MOR (Medication Observation Record) as indicated by medication technician initials in appropriate block or in electronic health record. The policy in part read medication will be ordered on demand or on a cycle fill in which medications on demand will be ordered when five days of medication is left in the package and cycle fill medications will be delivered on a date the community and pharmacy select with at least one full day of medication left in the package. The policy in part read the resident/responsible party will be billed directly. The policy in part read if a medication form cycle fill does not arrive on selected date, the HWD (health and wellness director) or designee will notify the pharmacy to deliver the medication on a stat basis or if the last dose is present and the medication is not available, the HWD or designee will call a local pharmacy to have the medication filled.

I reviewed Resident A's nurses' notes dated 4/7/2022 through 8/21/2022. Note dated 4/7/2022 in part read Resident A's family brought medications from an outside pharmacy into the facility for a procedure in which Employee #2 requested the family obtain a physician prescription so it could be faxed to the facility pharmacy, then placed on the MAR. Note dated 6/9/2022 read in part she was out of the facility on 6/8/2022 for a cataract procedure. Note dated 6/19/2022 read in part Resident A's family attends various physician appointments then fills the prescriptions in which family was educated that the facility would still need a signed physician prescription to order administer them.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(1) Medication shall be given, taken, or applied pursuant to labeling instructions or orders by the prescribing licensed health care professional.

ANALYSIS:	Staff attestations revealed the facility had changed electronic medication record systems in June 2022. Review of Resident A's face sheet revealed there were seven physicians listed in which six physicians had prescribed medications for her. Review of Resident A's physician orders revealed her medications could be administered whole or crushed. The medication orders did not read consistent with MARs in which there was insufficient information to determine the reason for the inconsistency. Review of Resident A's MARs revealed inconsistent documentation therefore it was undetermined if Resident A always received her medications as prescribed. For example, the August MARs read staff did not administer evening doses of Biofreeze on 8/8/2022 and 8/9/20222, however the morning dose on 8/9/2022 was initialed as given. Additionally, the medication pass reports did not always read the medication was "administered." For example, on 3/19/2022, 3/20/2022, 6/8/2022, 6/16/2022, 6/17/2022, the medication pass report was left blank under "date/time administered" and "date/time captured" for some medications, therefore it could not be determined if the medications were given or not. Furthermore, there were not "reasons/notes" for the medications being left blank. Based on this information, this allegation was substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Residents' dining tables and placements were not cleaned and disinfected after activities. Resident A's room was not cleaned.

INVESTIGATION:

On 8/10/2022, the department received a complaint submitted to the online complaint system which read resident's dining room tables were not cleaned after residents completed their activities between meals. On 8/10/2022, the department received additional allegations submitted by email from the complainant which read on the following dates there was fecal matter on Resident A's toilet seat, shower chair and floor: 6/6/2022, 6/22/2022, 6/24/2022, and 7/30/2022.

On 8/22/2022, I conducted an on-site inspection at the facility. I observed the facility's dining tables which were cleaned between breakfast and lunch. I observed the placements were removed from the tables and stacked in a pile. I observed part of the placements were in the sink. I observed the stack of placements appeared were worn but were clean. I observed the Devonshire unit kitchenette in which had a

shelf with paper towels, trash bags, red rags, stainless steel cleaner and disinfectant spray. A sign above the cleaning supply shelf read

Red Kitchen Rags

Only to be used in the Kitchen and Dining Room for disinfecting and cleaning the following:

- *Dishes*
- *Counters*
- *Tables*
- *Chairs*

USE A NEW RAG FOR EACH MEAL

Put dirty rags in the Red Rag Bucket on the floor

While on-site, I interviewed Employee #3 who stated after each meal, the dining area is cleaned including sanitization of the tables, chairs, and placements, as well as dishes were washed. Employee #3 stated staff re-set the tables with placements, silverware, napkins, and a drinking cup right before each meal. Employee #3 stated staff sanitize doorknobs, chairs, and common area surfaces after group activities in addition to the cleaning conducted by the housekeeping staff. Additionally, Employee #3 stated housekeeping staff conducted cleaning of residents' rooms twice weekly, however staff were to make each resident's bed daily, as well as ensure the resident's room and bathroom were clean. Additionally, Employee #3 stated housekeeping staff would conduct additional cleaning of a resident's room if needed.

While on-site, I interviewed Employee #4 who stated housekeeping staff worked Monday through Friday from 9:00 AM to 5:00 PM, as well as every other weekend. Employee #4 stated resident's rooms were cleaned bi-weekly and as needed, however they are checked daily by housekeeping. Employee #4 stated housekeeping cleaned the resident's bathroom including the shower and toilet, as well as dusted, vacuumed, and wiped down surfaces of their room. Employee #4 stated care staff make resident's beds and complete their personal laundry. Additionally, Employee #4 stated she ensures the public or common areas such as the dining rooms and bathrooms are cleaned and disinfected in each area of the facility.

While on-site, I observed Resident A's room and bathroom including the sink, shower, toilet, and toilet seat riser, which appeared clean. I observed Resident A's bed was made. On the Devonshire unit, I observed the residents' dining space after breakfast in which each table had been cleared and cleaned. I observed the placemats in the sink soaking in water. Additionally, I observed the Devonshire unit

hallways, locked kitchenette area, common living space, as well as the facility's front entrance and public bathrooms which all appeared clean.

Per email correspondence with Mr. May on 9/19/2022, which read consistent with previous staff interviews. The email read the maintenance director had implemented a log for housekeeping staff to maintain in July 2022 to record the cleaning conducted in the facility, as well as residents' rooms.

I reviewed Resident A's updated contract signed and dated 5/3/2022 by Relative A1 which read consistent with staff interviews.

I reviewed the housekeeping log sheets dated 7/18/2022 through 8/21/2022. The log sheets read each unit Asbury, Bradford, Carrington, Devonshire in which each resident room was listed, and staff checked off each occupied resident room with their initials, as well as other pertinent information. For example, the log sheet dated 8/1/2022 through 8/7/2022, read room 418 had feces on their carpet and it was shampooed. Additionally, the logs read the common areas were cleaned by housekeeping staff.

APPLICABLE RULE	
R 325.1979	**General maintenance and storage.**
	(1) The building, equipment, and furniture shall be kept clean and in good repair.
ANALYSIS:	Observations revealed the facility was cleaned at the time inspection. Staff interviews revealed caregivers and housekeeping staff worked to ensure residents' rooms were cleaned. Although the complainant noted specific dates, review of housekeeping documentation revealed the facility consistently maintained a cleaning schedule in which was consistent with Resident A's contract. Based on this information, this allegation was not substantiated
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Weekly menus were not posted.

INVESTIGATION:

On 8/10/2022, the department received additional allegations by email from the complainant which alleged the facility did not post the weekly menus.

On 8/22/2022, I conducted an on-site inspection at the facility. I interviewed Employee #3 who stated the weekly menus and resident's preferences were posted in the kitchenette of the unit.

While on-site, I observed the Devonshire unit kitchenette and resident dining area. The enclosed kitchenette area with locked door had a list of residents with their prescribed diets. The resident dining area did not have menus posted.

APPLICABLE RULE	
R 325.1953	**Menus.**
	(1) A home shall prepare and post the menu for regular and therapeutic or special diets for the current week. Changes shall be written on the planned menu to show the menu as actually served.
ANALYSIS:	Observations revealed regular diet menus, as well as the special and/or therapeutic diet menus, were not posted weekly for residents. Based on this information, this allegation was substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The facility was not accommodating Resident A's requests.

INVESTIGATION:

On 8/10/2022, the department received additional allegations submitted by email from the complainant which read Resident A had a restricted diet menu due to her gastric reflux. The complaint read dietary was provided a list of allowed foods and foods to avoid for Resident A, in which that list was supposed to be kept in Resident A's unit and the kitchen. The complaint read Resident A was served food she was supposed to avoid, and no other meal was offered. Additionally, the complaint read Resident A could not have the dessert served and requested alternative dessert which was not done.

On 8/22/2022, I conducted an on-site inspection at the facility. I interviewed Employee #3 who stated Resident A's preferences were posted in the kitchenette of the unit.

While on-site, I interviewed Employee #5 who stated the menus rotated through a five-week cycle and currently they were following the second cycle. Employee #5 stated the facility had accommodated resident's preferences as well as special or therapeutic diets. Employee #5 stated there were five residents who received a pureed diet, four residents who received mechanical soft diets, and seven residents who received finger foods. Employee #5 stated the facility tried to accommodate resident's food preferences in addition to their prescribed diets. Employee #5 stated for example, the kitchen and Resident A's unit kitchenette maintained a list of food preferences for her. Additionally, Employee #5 stated each unit's kitchenette had a resident snack bowl which was filled daily with fresh fruit, bars, and trail mix.

While on-site, I observed Resident A's food preference list in the unit kitchenette which read:

Foods to eat:
Breakfast: egg whites, jam, syrup, oatmeal, low fat yogurt
Meats: turkey, chicken, shrimp, baked fish, lean red meat
Fruits: blueberries, apples, pears, banana, melon
Vegetables: carrots, beets, green beans, spinach, peas, cauliflower, cucumber, celery, lettuce
Starch: brown rice, sweet potatoes, potatoes
Soups: broth based soups only
Drinks: decaf coffee

She may not have the following:
Fried food, pizza, chips, cheese, tomato-based sauces, citrus fruits, citrus juice, chocolate, peppermint, carbonated beverage, caffeinated beverage, whole dairy, whole eggs, bacon, sausage, corn

Additionally, I observed the resident's snack bowl in the kitchenette which contained but was not limited to bananas, chocolate chip cookies, fig newton bars, and trail mix.

I reviewed Resident A's diet order dated 7/22/2020 which read she was prescribed a Regular diet. The order did not read she had special requests.

I reviewed the cycle two menus from July through August 21, 2022, which read residents were offered desserts at lunch and dinner, as well as a sugar free dessert of choice. The menus read in part examples desserts offered were but not limited to brownie, frosted yellow cake, oatmeal raisin cookie, ice cream, iced pound cake, fruit cobbler, applesauce cake, pudding, pie of choice, assorted cookies, and dessert of choice. The menus read there were three snacks served per day, morning, afternoon, and evening snacks. The facility maintained a menu substitution form in which documented the date, the planned menu item, the resident's substituted menu item and reason for substitution, as well as the staff's initials. For example, on

8/19/2022, the planned menu item was wild rice, and the substituted menu item was roasted red potatoes, in which the reason for substitution was resident choice.

I reviewed the production sheets from July 2022 through August 21, 2022, which read consistent with the menus. The production sheets read residents chose the alternative menu or dessert options offered.

APPLICABLE RULE	
R 325.1952	**Meals and special diets.**
	(2) A home shall work with residents when feasible to accommodate individual preferences.
ANALYSIS:	Review of documentation and observations revealed Resident A was prescribed a regular diet by her physician in which the facility maintained a list of her food preferences to follow. Review of the menus revealed there was a dessert offered twice a day as well as alternative dessert or option of a snack. Based on this information, this allegation cannot be substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident units lacked cleaning supplies.

INVESTIGATION:

On 8/10/2022, the department received additional allegations submitted by email from the complainant which read there were no available cleaning supplies on Resident A's unit when housekeeping was not available.

On 8/22/2022, I conducted an on-site inspection at the facility. I interviewed administrator Tyler May who stated staff had access to cleaning supplies when housekeeping staff was not on duty. Mr. May stated the facility utilized agency staff prior so it may have been an isolated incident where the staff member was unable to locate the cleaning supplies. Mr. May stated the basement janitor supply closet was always open for staff since it was the entry way to the laundry area. While on-site, Mr. May inquired with two staff members on duty where he could find additional cleaning supplies in which the staff replied in the in the janitor closets, which were located on the Bradford unit or in the hallway next to the Carrington and Devonshire units. The staff also stated they could find additional supplies in the basement.

While on-site, I interviewed Employee #3 whose statements were consistent with Mr. May's interview. Employee #3 stated there was disinfectant spray and wipes located in the locked kitchenettes as well.

While on-site, I interviewed Employee #4 whose statements were consistent with previous staff interviews. Employee #4 stated she ensured the bathrooms, and all kitchenette areas were stocked with supplies such as disinfectants, however staff had access to the supply closet in the basement if needed.

While on-site, I observed the Devonshire kitchenette in which there was Oxivir Tb disinfectant spray and paper towels. I observed the Corrington and Devonshire hallway janitor closet which maintained a mop, mob bucket, Mr. Clean floor cleaner, and Bleach wipes. I observed the basement janitor supply closet which maintained nine bottles of Oxivir Tb, as well as other various cleaning supplies. I observed the housekeeping supply cart which also maintained various cleaning supplies including the Oxivir Tb.

On 8/22/2022, I conducted a telephone interview with afternoon staff Employee #6 whose statements were consistent with previous staff interviews. Employee #6 stated there was always shift supervisor on duty who could also assist with obtaining cleaning supplies if staff were unable to locate them.

APPLICABLE RULE	
R 325.1967	**Resident rooms.**
	(8) Each resident occupied floor shall have a janitor's closet.
For Reference: R 325.1979	**General maintenance and storage.**
	(3) Hazardous and toxic materials shall be stored in a safe manner.
ANALYSIS:	Staff attestations and observations revealed there were sufficient cleaning supplies available for staff use, thus there was insufficient evidence to support this allegation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The facility lacked paper towels and soap at dining room sink.

INVESTIGATION:

On 8/10/2022, the department received additional allegations submitted by email from the complainant which alleged there were no paper towels or soap at the dining room sink.

On 8/22/2022, I conducted an on-site inspection at the facility. I interviewed Employee #3 who stated housekeeping maintained the supplies needed for the dining room sink. Employee #3 stated if housekeeping staff were not on duty, staff could obtain the needed supplies from the basement or request their shift supervisor obtain the supplies.

While on-site, I interviewed Employee #4 whose statements were consistent with Employee #3. Employee #4 stated she ensured each dining room sink area was stocked with paper towel and soap daily.

While on-site, I observed the Devonshire unit's dining room sink area in which the paper towel and soap dispensers were full. I also observed the paper towel and soap dispensers were full in Devonshire's kitchenette, the main kitchen, and public bathroom located at the entrance of the facility.

APPLICABLE RULE	
R 325.1980	**Soap and towels.**
	Soap and single use towels shall be available for the use of employees and visitors. Use of the common towel is prohibited.
ANALYSIS:	Observations revealed the paper towel and soap dispensers were full, as well as additional supplies of each were in the basement. Staff attestations revealed a plan in which staff were able to obtain supplies if needed. Based on this information, this allegation was unsubstantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The facility lacked sufficient supply of COVID personal protective equipment.
The facility lacked always locking the front entrance door.

INVESTIGATION:

On 8/10/2022, the department received additional allegations submitted by email from the complainant which alleged there was insufficient supply of personal protective equipment (PPE) in the isolation carts outside resident rooms, as well as no hazardous waste baskets. The complaint read residents were allowed to leave their rooms after completion of the five-day protocol Paxlovid without being retested. Additionally, the complaint alleged the front door entrance of the building was locked at night and staff would prop the door open when going outside for a break which was a safety risk.

On 8/22/2022, I conducted an on-site inspection at the facility. I interviewed Mr. May who stated he completed notifications to the local health department every Wednesday. Mr. May stated the Bradford unit was currently under quarantine at the time of inspection for a COVID-19 outbreak. Mr. May stated the facility had sufficient supply of COVID-19 PPE. Mr. May stated occasionally an isolation cart is shared between two rooms. Additionally, Mr. May stated the front entrance door was locked after the front desk staff left for the day. Mr. May stated staff or visitors rang the doorbell which rang to each unit Asbury, Bradford, Carrington, and Devonshire (A, B, C, and D) in the facility. Mr. May stated each unit had a locked keypad entrance. Additionally, Mr. May stated the Carrington and Devonshire units had an additional locked keypad door prior to the entryway of those locked units.

While on-site, I observed the locked front entrance door, as well as observed staff operate the locked keypad doors of each unit. I observed the locked keypad door that separated the Asbury and Bradford units from the Carrington and Devonshire units.

While on-site, I observed the COVID-19 PPE supplies maintained in the maintenance director's office. The maintenance director conducted a count of all PPE supplies which read four boxes of medium gloves (4000 pieces), two boxes of large gloves (2000 pieces), 200 isolation gowns, 48 – 16.9 oz hand sanitizers, 48 bleach wipe containers, 500 COVID-19 tests, 110 face shields, 30 shoe covers, 50 – N95 masks (more ordered on 8/19/2022), 500 surgical masks, and seven isolation carts.

While on-site, I observed the COVID-19 employee and visitor screening log, a sign posted on the Bradford unit door which informed staff/visitors there was COVID-19 on the unit, as well as sign to double mask. I observed all staff and visitors wearing masks. I observed the entryway screening area offered staff/visitors sanitizer and surgical masks.

While on-site, I observed a picture from the Bradford unit in which an isolation cart was located outside a resident door. The picture showed the top of the isolation cart which maintained two Center for Disease Control (CDC) forms. The CDC forms read Sequence for Donning Personal Protective Equipment (PPE) and Sequence for Removing Personal Protective Equipment (PPE). Additionally, the picture showed a trash can located inside the resident room with a red hazardous bag.

On 8/22/2022, I conducted a telephone interview with afternoon staff Employee #6 whose statements were consistent with Mr. May. Employee #6 stated the front entrance was locked in the evenings in which each unit was notified when there was a visitor or staff at the front entrance. Employee #6 stated if the staff propped the front entrance door open, then herself or other shift supervisors would educate staff to keep it closed. Employee #6 stated she had not observed staff prop the front entrance door open. Employee #6 stated the facility had sufficient supply of PPE for staff and visitors.

I reviewed the CDC website Ending Isolation and Precautions for People with COVID-19: Interim Guidance (cdc.gov) which read

> *People who are infected but asymptomatic or people with mild COVID-19 should isolate through at least day 5 (day 0 is the day symptoms appeared or the date the specimen was collected for the positive test for people who are asymptomatic). They should wear a mask through day 10. A test-based strategy may be used to remove a mask sooner.*

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following: **(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.**
ANALYSIS:	Staff attestations revealed the facility had an organized program in place in accordance the Wayne County health department and CDC for COVID-19. Additionally, there was sufficient COVID-19 PPE supplies maintained at the time inspection. Observations of the doors throughout the facility revealed a locking method which maintained resident safety and protection. Based on this information, there was insufficient evidence to support these allegations.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A's service plan was not updated.

INVESTIGATION:

On 8/10/2022, the department received additional allegations submitted by email from the complainant which alleged Resident A's service plan had not been updated since 2020. The email read Resident A's service plan read she was ambulatory and able to dress herself.

While on-site, I interviewed Employee #3 who stated Resident A required assistance with dressing and ambulation.

While on-site, I observed staff assist Resident A with ambulation to an activity.

I reviewed Resident A's service plan dated 2/14/2022 which read in part she needed assistance with dressing daily and as needed. The plan read Resident A needed assistance with escorting and transfers daily and as needed. The plan read Resident A's authorized representative was emailed the updated service plan on 2/14/2022.

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.
ANALYSIS:	Review of Resident A's service plan revealed it had been updated on 2/14/2022 and read she required staff assistance with dressing as well as ambulation. Based on this information, this allegation cannot be substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A's hands were not washed before meals with either soap or hand sanitizer. Resident A's brief was not changed. Resident A's ted hose stockings were not checked by staff. Resident A had two incidents at the facility.

INVESTIGATION:

On 8/10/2022, the department received a complaint submitted to the online complaint system, as well as additional complaints submitted by email, which read Resident A's hands were not washed before meals with either soap or hand sanitizer. The complaint read Resident A's briefs were not changed. The complaint

read Resident A's ted hose rolled down her leg and were not checked to ensure proper placement. The complaint read Resident A had two incidents, one in January 2022 in which she had a broken rib, and the other was 8/1/2022 in which she had a bruise on her right wrist.

On 8/22/2022, I conducted an on-site inspection at the facility. I interviewed Employee #3 who stated at the start of her shift, she rounded on all the residents at to ensure their briefs were clean and dry, then provided showers prior to breakfast to those who were scheduled for that day. Employee #3 stated Resident A had received care consistent with her service plan and did not have wounds or excoriation on her buttock area. Employee #3 stated residents were offered toileting prior to each meal in which their briefs were changed in which they would have the opportunity to wash or sanitize their hands. Employee #3 stated staff also utilized wipes to assist with hand cleaning. Employee #3 stated the facility's life enrichment coordinator would often help residents prior to meals to ensure their hands were cleaned. Employee #3 stated staff applied Resident A's ted hose and would also take them off at night. Employee #3 stated Resident A would often roll her ted hose stockings down in which she would pull them up after toileting.

While on-site, I observed Resident A who appeared clean and groomed as well as dressed in clean clothing. I asked Resident A if I could observe her ted hose, in which she declined. I observed a small bruise on the top of Resident A's right hand and when asked how it happened, she responded "that was always there."

Per email correspondence with Employee #2 on 9/20/2022, nurses' notes for Resident A were maintained from 4/7/2022 through current.

I reviewed Resident A's face sheet which read Relative A1 was her power of attorney.

I reviewed Resident A's service plan which read Resident A's primary diagnosis was Alzheimer's. The plan read Resident A required assistance for all aspects of bathing, daily hygiene, dressing, transfers/escorting places, bathroom use, dining to assure she ate her meals and consumed fluids. The plan read Resident A required reminders and redirection daily. The plan read she was sometimes incontinent. Resident A's service plan read she was at risk for falls.

On 9/21/2022, I conducted a telephone interview with Employee #2 who stated Resident A had occasional falls prior. Employee #2 stated Resident A's facility records maintained an email record of an x-ray received by email on 1/28/2022. Employee #2 stated the x-ray was completed on 1/24/2022 and had displaced rib. Employee #2 stated there were no physician orders pertaining to x-ray results. Employee #2 stated Resident A utilized her own primary care physician Dr. Walford, so they did not maintain the physician records or orders unless they were received by her family. Employee #2 stated Resident A's records read their facility physician

evaluated her on 1/19/2022 in which occurred if a resident's family provided permission to be seen by their physician as well.

I reviewed Resident A's physician note dated 1/19/2022 which in part read under diagnosis and assessment "Alzheimer's disease, unspecified" and "fall." The note read in part the plan was to continue Alzheimer's medications and physical/occupational therapy.

I reviewed the email records of Resident A's x-ray. The email read it was received 1/28/2022 and was printed from Resident A's Epic My Chart records. The email read on 1/24/2022, *evaluation was limited by osteopenia and overlap, and there was mildly displaced fracture of the right anterior seventh rib*. The email read her primary care physician was Dr. Walford.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(1) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.
For Reference: R 325.1933	**Personal care of residents.**
	(2) A home shall afford a resident the opportunity and instructions when necessary for daily bathing, oral and personal hygiene, daily shaving, and hand washing before meals. A home shall ensure that a resident bathes at least weekly and more often if necessary.
ANALYSIS:	Review of Resident A's medical records revealed she had history of Alzheimer's disease and falls. Staff attestations and observations revealed there was insufficient evidence to determine that Resident A had not received care consistent with her service plan. Resident A's medical records revealed her primary care physician would have been apprised of the displaced rib in which the facility lacked follow up orders to implement interventions. Additionally, it could not be determined the cause of Resident A's bruise on her hand. Based on this information, these allegations could not be substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The facility has one medication technician for three units.

INVESTIGATION:

On 8/10/2022, the department received a complaint submitted to the online complaint system which read on several occasions there was one medication technician to pass medications on all three residential units. The complaint read there was one medication technician on duty for the following dates: 6/22/2022, 6/29/2022, 7/16/2022, 7/17/2022, 7/22/2022, 7/23/2022, 7/24/2022, 7/30/2022, 8/6/2022, 8/13/2022, and 8/14/2022. The complaint read there were two medication technicians most weeknights. The complaint read there was one medication technician for two units on 8/15/2022 who attempted to administer Resident A's medications late however they were not given because she was sleeping.

On 8/22/2022, I conducted an on-site inspection at the facility. I interviewed Mr. May who stated there were four neighborhoods Asbury, Bradford, Carrington, and Devonshire in the facility but currently the Asbury neighborhood was under construction so there were no residents on that unit. Mr. May stated he had utilized some agency staff, nonetheless there were two staff on each neighborhood, one of which was a medication technician. Mr. May stated sometimes the neighborhoods had to share a medication technician. Mr. May stated each neighborhood would have at least two caregivers if one medication technician was on duty as well as the resident care manager. Mr. May stated the resident care manager on duty was also trained to provide medications if staff needed assistance or called off duty.

While on-site, I reviewed the July and August 2022 staff schedule which read consistent with statements from Mr. May.

While on-site, I interviewed Employee #7 who stated medications were to be administered one hour prior and one hour after the time the medication was due to be given. Employee #7 stated resident care manager could assist with medications if needed. Employee #7 stated occasionally resident's medications may be administered late if there was an emergency or incident with a resident in which it would be documented in the MAR.

On 8/22/2022, I conducted a telephone interview with afternoon staff Employee #6 whose statements were consistent with Mr. May and Employee #7. Employee #6 stated the medication technicians would request assistance if needed to ensure medications were passed.

Review of Resident A's January through August 2022 MARs revealed staff documented reasons medications were late or not administered.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(5) The home shall have adequate and sufficient staff on duty at all times who are awake, fully dressed, and capable of providing for resident needs consistent with the resident service plans.
ANALYSIS:	Review of the facility staffing records revealed a medication technician was on duty to administer medications as prescribed. It could determine if the number of medication technicians on duty correlated with times medications were administered or not since the MARs did not maintain times medications were administered.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 11/16/2022, I shared the findings of this report with authorized representative Mr. Levy by voicemail.

IV. RECOMMENDATION

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

9/26/2022

_____

Jessica Rogers Date
Licensing Staff

Approved By:

11/16/2022

_____

Andrea L. Moore, Manager Date
Long-Term-Care State Licensing Section