GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 8, 2021

Michele Locricchio
Anthology of Northville
44600 Five Mile Rd
Northville, MI 48168

RE: License #: AH820399661
Investigation #: 2021A1026012 Anthology of Northville

Dear Ms. Locricchio:

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 (616) 356-0183.

Sincerely,

Andrew Schefke, Licensing Staff
Bureau of Community and Health Systems
350 Ottawa, N.W.
Grand Rapids, MI 49503
(517) 897-1560

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH820399661
Investigation #:	2021A1026012
Complaint Receipt Date:	12/08/2020
Investigation Initiation Date:	12/08/2020
Report Due Date:	02/08/2021
Licensee Name:	CA Senior Northville Operator, LLC
Licensee Address:	44600 Five Mile Rd Northville, MI 48168
Licensee Telephone #:	(312) 994-1880
Administrator:	Michele Locricchio
Authorized Representative:	Jeffrey Madak
Name of Facility:	Anthology of Northville
Facility Address:	44600 Five Mile Rd Northville, MI 48168
Facility Telephone #:	(248) 697-2900
Original Issuance Date:	08/12/2020
License Status:	TEMPORARY
Effective Date:	08/12/2020
Expiration Date:	02/11/2021
Capacity:	103
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Facility staff was physically abusive to Resident A.	No
Facility staff stole items from Resident A's room.	No
A facility staff member brought COVID-19 into the facility, resulting in 12 Resident deaths.	No
The facility did not provide care that encouraged Resident A to function physically and intellectually at the highest practical level.	No
The facility did not follow Resident A's service plan.	Yes
Resident A's medications were not properly administered.	Yes
The facility did not meet Resident A's personal care and personal hygiene needs.	Yes
The facility did not properly launder Resident A's laundry.	No
Additional Findings	No

III. METHODOLOGY

12/08/2020	Special Investigation Intake 2021A1026012
12/08/2020	Special Investigation Initiated - Letter APS referral sent via email.
01/25/2021	Contact - Telephone call made Telephone interview conducted with Relative A1.
01/25/2021	Contact - Telephone call made Telephone interview conducted with Relative A2.
01/25/2021	Contact - Telephone call made Initiated investigation with facility administrator.
01/25/2021	Contact - Telephone call made Microsoft Teams video call interview conducted with Relative A2.

02/03/2021	Contact - Telephone call made Microsoft Teams video call interview conducted with caregiver Johnna Mitchell.
02/03/2021	Contact - Telephone call made Microsoft Teams video call interview conducted with caregiver Carleta Thompson.
02/03/2021	Contact - Telephone call made Microsoft Teams video call interview conducted with medication and care manager Tiffany Craig.
02/03/2021	Contact - Telephone call made Microsoft Teams video call interviews conducted with Residents B, C, and D.
02/03/2021	Contact - Telephone call made Telephone interviews conducted with Residents E and F.
02/11/2021	Contact - Telephone call received Telephone interview conducted with detective Schwartzenberger.
03/01/2021	Exit Conference Conducted with facility AR by telephone.

ALLEGATION:

Facility staff was physically abusive to Resident A.

INVESTIGATION:

On 12/8/20, licensing staff received a complaint intake.

On 1/25/21, a telephone interview was conducted with Relative A1. Relative A1 stated that Resident A's family became concerned after noticing bruises on the Resident. According to Relative A1, the family put cameras in Resident A's room and contacted the Northville Police Department due to these concerns.

On 1/25/21, a telephone interview was conducted with Relative A2.

On 1/25/21, a video call was conducted with Relative A2, during which, Relative A2 provided video footage from the camera that was placed in Resident A's room. It

was noted that there was no video footage of facility staff striking, grabbing, or otherwise abusing Resident A.

On 1/25/21, telephone and email correspondence were initiated with facility administrator Jeffrey Madak, and subsequent correspondence ensued, with Mr. Madak providing responses, facility documents, and parts of Resident records beginning on 1/27/20.

On 2/3/21, a video call interview was conducted with caregiver Johnna Mitchell. Ms. Mitchell stated that she is unaware of any instances where facility staff members have exhibited violent or abusive behaviors while working in the facility.

On 2/3/21, video call interviews were conducted separately, with caregiver Carleta Thompson and medication and care manager Tiffany Craig. The statements of Ms. Thompson and Ms. Craig were consistent with those of Ms. Mitchell, with regard to staff temperament and behavior towards Residents.

On 2/3/21, video call interviews were conducted separately, with Residents B, C, and D, and phone call interviews were conducted separately, with Residents E and F. All five Residents made similar statements regarding the staff being, kind, friendly, polite, and helpful.

On 2/11/21, a telephone interview was conducted with detective Schwartzenberger of the Northville Township Police Department. According to detective Schwartzenberger, a complaint against the facility and its caregiver(s) was filed with the police department, alleging in-part that there was excrement in Resident A's room and that Resident A had unexplained bruises believed to be caused by facility staff. Detective Schwartzenberger stated that Resident A's bruises were examined during an on-site inquiry, but that the bruises were not consistent with abuse and instead looked as though they were caused by incidental bumps and falls. According to detective Schwartzenberger, there was no observed excrement in Resident A's room. Detective Schwartzenberger stated that following the investigation, the case was closed, as there was no evidence of abuse.

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 that is subject to chapter 35 of the insurance code of 1956, 1956 PA 218, MCL 500.3501 to 500.3573, the health facility or agency shall post the policy at a public place in the health facility or agency and shall provide the policy 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:	Based on interviews with facility staff, Residents, and detective Schwartzenberger, this allegation could not be substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Facility staff stole items from Resident A's room.

INVESTIGATION:

Relative A1 stated that items were stolen from Resident A's room.

Ms. Mitchell, Ms. Thompson, and Ms. Craig all stated that they were unaware of any allegations or instances of facility staff or other Residents removing or stealing items from Residents' rooms.

According to detective Schwartzenberger, there were no allegations of theft included in the complaint filed with the police department.

Resident A's signed lease was reviewed. It was noted that a clause in the lease reads "The Residence is not responsible for loss of property belonging to You due to theft or any other cause unless such loss is caused by the negligent or intentional acts of the Residence or its employees or agents."

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:	Based on interviews with facility staff and detective Schwartzenberger, and a review of facility records, this allegation could not be substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

A facility staff member brought COVID-19 into the facility, resulting in 12 Resident deaths.

INVESTIGATION:

Relative A1 alleged that a facility staff member attended a destination wedding and did not tell anyone at the facility. According to Relative A1, that staff member was infected with COVID-19 when they returned to work and was the source of an outbreak that resulted in the deaths of 12 memory care Residents.

According to Mr. Madak, there was an employee who attended a destination wedding. However, Mr. Madak stated that upon their return, that employee tested negative prior to testing positive. Mr. Madak stated that the employee tested positive after working with COVID-19 positive Residents, during an outbreak that the facility traced back to a Resident's family member. Mr. Madak stated that the outbreak infected 16 Residents and 6 passed away.

The facility's policies, procedures, and protocols pertaining to COVID-19 and the facility's screening process were reviewed and determined to be appropriate.

APPLICABLE RULE	
R 325.1923	**Employee's health.**
	(1) A person on duty in the home shall be in good health. Files shall be maintained containing evidence of adequate health, such as results of examinations by a qualified health care professional and tuberculosis screening which consists of an intradermal skin test or chest x-rays, or other methods recommended by the local health authority. Records of accidents or illnesses occurring while on duty that place others at risk shall be maintained in the employee's file.
ANALYSIS:	Based on an interview with the facility administrator and a review of facility documentation, this allegation could not be substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The facility did not provide care that encouraged Resident A to function physically and intellectually at the highest practical level.

INVESTIGATION:

Relative A1 alleged that Resident A forgot how to speak, because nobody in the facility interacted or spoke with the Resident.

According to Ms. Thompson, Resident A did not participate in facility activities, but was capable of having conversations, and had no problems with speaking or interacting with staff or other Residents.

According to Ms. Craig, Resident A would speak and interact with other Residents and staff, but wasn't overly conversational.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(1) Personal care and services that are provided to a resident by the home shall be designed to encourage residents to function physically and intellectually with independence at the highest practical level.
ANALYSIS:	Based on staff interviews, this allegation could not be substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The facility did not follow Resident A's service plan.

INVESTIGATION:

On 12/8/20, licensing staff received a complaint intake that alleged in-part that on 12/6/20, Resident A went 14 hours without being checked on by facility staff. The complaint also alleged that Resident A was put to bed fully clothed.

Relative A1 restated these allegations.

Relative A2 restated these allegations and also alleged that facility staff improperly transferred Resident A.

Resident A's service plan was reviewed. It was noted that Resident A required a moderate level of assistance with dressing and that "[Resident A] prefers to sleep in [their] protective underwear and a t shirt at night but may occasionally wear pajama bottoms." It was also noted that Resident A required a moderate level of assistance with transferring and that "[Resident A] will also need help with transferring into bed with getting [their] legs into bed at night." Additionally, the service plan read that "staff are to perform wellness checks every 2 hours to assure [Resident A] is safe", due to Resident A's high potential for falls.

According to Ms. Thompson and Ms. Craig, Resident A was unable to dress/undress on their own.

Video footage from the camera in Resident A's room was reviewed:

On 12/3/20, a staff member was observed helping Resident A into bed, while Resident A was still fully dressed, at approximately 8:30pm. The staff member tells Resident A that they will be right back, but nobody re-enters the room until approximately 6:38am the next morning (12/4/20). Resident A remained fully dressed, and their room lights and TV were on all night. It was noted that the camera provided a view of Resident A's room door, which was not observed to have been opened by staff during the night to check on Resident A.

On 12/4/20, a staff member assists Resident A in transferring from their chair to their bed at approximately 7:49pm. It is noted that Resident A's pants are down around their knees, as the staff member holds their hand and assists them in transferring to the bed.

On 12/5/20, a staff member assists Resident A into bed at approximately 8:00pm. Nobody re-enters the room until approximately 8:28am on 12/6/20.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(2) 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.
ANALYSIS:	Based on a review of video footage, it was determined that staff did not check on Resident A every two hours, that staff transferred Resident A in an unsafe manner, and that staff put resident A to bed fully dressed. These allegations are substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A's medications were not properly administered.

INVESTIGATION:

On 12/8/20, licensing staff received a complaint intake that alleged in-part that, Resident A is not receiving their medication correctly.

Relative A1 and A2 restated this allegation.

Resident A's medication administration record (MAR) was reviewed from September-December. It was noted that numerous medication doses were not administered during this timeframe. On these occasions, there were no additional notes or exceptions documented in Resident A's MAR to explain why these medications were not administered.

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:	Based on a review of Resident A's record, this allegation is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The facility did not meet Resident A's personal care and personal hygiene needs.

INVESTIGATION:

Relative A1 alleged that the facility did not give Resident A showers, did not assist Resident A with eating, and did not brush Resident A's teeth. Additionally, Relative A1 stated that Resident A was on their third mattress, because staff did not change Resident A's briefs or the pad on the bed in a timely manner, and that staff did not adequately clean Resident A when they did change the Resident's briefs.

According to Ms. Mitchell, staff assist Residents with their personal care needs, including showering, eating, brushing teeth, and changing briefs/pull-ups. Ms. Mitchell stated that staff does a thorough job and that there are no issues that she's aware of with staff failing to provide assistance in a timely manner.

Ms. Thompson and Ms. Craig made similar statements regarding Resident A's meal activity. Both stated that Resident A would dine in the dining room, and that Resident A was a good eater who required only minimal assistance.

Between Residents B, C, D, E, and F, there is a wide range of individual needs and level of assistance provided by the facility. None of the Residents interviewed voiced concerns over their personal care or hygiene needs.

Resident A's monthly task log was reviewed from September-December. According to Mr. Madak, staff are expected to initial/document in the monthly task log when attending to Residents' personal care and personal hygiene needs. It was noted that staff frequently documented "TNC" (task not completed) in Resident A's task log for personal care and personal hygiene tasks, including bathing and grooming/personal hygiene.

APPLICABLE RULE	
R 325.1933	**Personal care of residents.**
	(1) A home shall provide a resident with necessary assistance with personal care such as, but not limited to, care of the skin, mouth and teeth, hands and feet, and the shampooing and grooming of the hair as specified in the resident's service plan.
ANALYSIS:	Based on interviews with facility staff and Residents, and a review of Resident A's record, allegations pertaining to Resident A's eating needs and toileting/clean-up needs could not be substantiated. Based on a review of Resident A's record, it was determined that staff frequently documented tasks related to Resident A's personal care and personal hygiene needs (showers and oral care) as not being completed. This allegation is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The facility did not properly launder Resident A's laundry.

INVESTIGATION:

Relative A1 alleged that Resident A's laundry was mixed with other Residents' laundry. According to Relative A1, they witnessed other Residents wearing Resident A's clothing.

Ms. Mitchell, Ms. Thompson, and Ms. Craig all made similar statements, asserting that they are unaware of any issues with Residents' laundry being mixed and/or Residents receiving the wrong clothes.

None of the Residents interviewed (Residents B, C, D, E, and F) had any issues or voiced any concerns about how laundry is done in the facility.

APPLICABLE RULE	
R 325.1935	**Bedding, linens, and clothing.**
	(3) The home shall make adequate provision for the laundering of a resident's personal laundry.
ANALYSIS:	Based on facility staff and Resident interviews, this allegation could not be substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

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

2/16/21

Andrew Schefke Date
Licensing Staff

Approved By:

3/1/21

Russell B. Misiak Date
Area Manager