GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 24, 2021

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

RE: License #: AH820399661
Investigation #: 2021A1011023
Anthology of Northville

Dear Ms. Locricchio:

Attached is the Special Investigation Report for the above referenced facility. Due to the severity of the violations, disciplinary action against your license is recommended. You will be notified in writing of the department's action and your options for resolution of this matter.

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,

Andrea Krausmann, Licensing Staff
Bureau of Community and Health Systems
51111 Woodward Avenue 4th Floor, Suite 4B
Pontiac, MI 48342
(586) 256-1632

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH820399661
Investigation #:	2021A1011023
Complaint Receipt Date:	03/22/2021
Investigation Initiation Date:	03/22/2021
Report Due Date:	05/21/2021
Licensee Name:	CA Senior Northville Operator, LLC
Licensee Address:	44600 Five Mile Rd Northville, MI 48168
Licensee Telephone #:	(312) 994-1880
Administrator:	Jeffrey Madak
Authorized Representative:	Michele Locricchio
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:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Staff were unresponsive to resident calls for assistance, resident family member multiple calls for assistance, and emergency first responders attempt to gain access to the building.	Yes
Resident A did not receive care in accordance with her service plan.	Yes
The facility is short staffed.	Yes
Resident A’s room door would not latch and posed a fire hazard.	Yes
Additional Findings	Yes

III. METHODOLOGY

03/22/2021	Special Investigation Intake 2021A1011023
03/22/2021	Special Investigation Initiated - Letter Referral made to adult protective services (APS) via email.
03/22/2021	Contact - Document Received Incident report from facility received.
03/23/2021	Referral - Office of Fire Safety Informed BFS inspector Larry DeWachter of fire safety allegations by telephone.
03/23/2021	Contact - Document Received Email from BFS inspector L. DeWachter that he contacted Northville FD Fire Marshal Tom Hughes
03/29/2021	Contact - Document Received BFS supervisor L. DeWachter forwarded email from Tom Hughes Fire Marshal of Northville Township fire department.
04/07/2021	Contact - Telephone call received Interviewed complainant.
04/07/2021	Contact - Telephone call made

	Called Northville PD dispatcher Keith Bingham re: police report.
04/07/2021	Contact - Document Sent Emailed request for police report
04/07/2021	Inspection Completed On-site Interviews conducted and records reviewed.
04/08/2021	Contact - Telephone call made Interviewed EMS Coordinator William Caruso.
04/08/2021	Contact – Document Received Midnight shift call-alert response times
04/09/2021	Contact – Document Received Northville Twp. Police Dept. Case Report 210009788 written by Justin Norlock.
04/13/2021	Contact – Telephone call received William Caruso called with dispatch audio/telephone recordings.
04/27/20210	Contact – Document Received Letter dated 3/22/21 from Complaint Coordinator [no name] at DHHS Oakman Adult Services District.
05/05/2021	Exit Conference – Conducted with licensee authorized representative Michele Locricchio by telephone.

ALLEGATION:

Staff were unresponsive to resident calls for assistance, resident family members multiple calls for assistance, and emergency first responders attempt to gain access to the building.

INVESTIGATION:

On 3/22/21, the allegations were received via the on-line intake unit and I made a referral to adult protective services. On 3/23/21, I made a referral to Bureau of Fire Services (BFS). On 3/29/21, I received an email in which responding fire fighter/paramedic Kyle Lewis detailed the events that occurred on 3/21/21 and had sent them to Northville Township fire marshal Tom Hughes. The documentation by Mr. Lewis coincided with the allegations of this complaint. On 4/7/21, I interviewed the complainant by telephone. The complainant reported having received the information from another individual and notified the department.

According to the written allegations received and documentation by firefighter/paramedic Kyle Lewis to Mr. Hughes, on 3/21/21 Resident A used a call pendant requesting staff assistance for over two hours. When no one responded, Resident A contacted her family, who in turn, called 911. The Northville Township fire department fire fighters/paramedics Kyle Lewis and Christopher Kolinski were dispatched at 4:22 am. Upon arrival when they were unable to gain entry, dispatch advised they tried calling several numbers at Anthology, but there were no answers. The first responders entered the after-hours door code into the keypad system, but it would not open the front or rear doors. No one inside Anthology of Northville responded to the intercom systems, including the intercom labeled for emergency use. Inside the facility's knox box, a safe that holds building keys for fire departments, medics and police, two hard keys and four key cards were located, but none worked at the front door, the memory care door around back, the riser room door, nor another maintenance door. The knox box at the back of the building had the same complement of keys, which also did not work. The 911 dispatch tried to call the facility continually for over 30 minutes with no response. The next step was to force entry. A staff member heard the commotion and came out the second-floor balcony, and responded she would meet and allow them entrance at the front door. Local police also responded at this time and entered the facility at the same time. They immediately went to Resident A's room, located on the third floor, where they found her door open and she was yelling for help. The resident requested assistance getting to the restroom and changing her soaked brief. Staff assisted her while we made contact with the 911 RP [reporting person]. The RP stated [Resident A] had activated the pendant roughly two hours ago and did not receive any help. She also advised the same thing happened just the night before and management assured her there would not be a problem again.

On 4/7/21, I interviewed administrator Jeffrey Madak, director of health and wellness Laura Kujawski, and resident care coordinator Jasmine Parker at the facility. I also reviewed documentation from Resident A's record and related facility documentation while at the facility. Additional documentation was provided via email from Mr. Madak on 4/8 and 4/9/21, upon request.

Jeffrey Madak said he did not know why the phones were reportedly not answered on 3/21/21. Mr. Madak said he checked the phone system with the local fire marshal Tom Hughes after the incident and they found no problem with the phones ringing. He did not know why the fire department and dispatcher's calls to the facility were not answered. Mr. Madak explained that the facility's phone system is programmed that after the receptionist leaves for the day, calls go to a portable phone. Staff are expected to keep the portable phone with them. If the phone is not answered after a number of rings it is supposed to ring to Mr. Madak's personal phone. Mr. Madak said if he is sleeping, his phone accepts voice mail messages, and he responds to the message. Mr. Madak said there was a problem with the system at one time, because when he would answer the phone, no one would be there, or the caller could not hear him. Mr. Madak said he believes the system has been corrected and is functioning as expected.

Laura Kujawski said there has been a problem with the phone system for quite some time. Ms. Kujawski said there have been a lot of complaints that the phones are not answered between 8 pm to 8 am, when the front desk shuts down. Ms. Kujawski said when the phone is not answered, it is supposed to "elevate" to Mr. Madak's personal phone, but it has not been working.

Jasmine Parker explained that she scheduled three staff on duty the midnight shift from 11:00 pm on 3/20/21 to 7:30 am on 3/21/21. Staff Denise Goggins did not show up for her shift. Staff Shante Gardner called in and initially said she would arrive at 1:00 am but later reported she would not be coming in. That would leave staff Gerrome Smiley on duty alone, but staff LaQuarius "Q" Hudson reported for work to cover Ms. Goggins' shift. Ms. Hudson would be the supervisor/medication technician on duty. The staff schedule confirmed this information.

Ms. Parker explained if staff notify her that a staff member did not report for duty, then Ms. Parker comes in and covers the shift, but Ms. Hudson did not notify Ms. Parker as expected. Consequently, Ms. Hudson and Mr. Smiley worked short-staffed midnight shift of 3/20-3/21/21, with only the two of them on-duty. Ms. Parker said she called the facility in morning about 5:30 am and that is when Ms. Hudson informed her that Ms. Gardner did not report for duty.

Ms. Parker said she did not know about the fire department arriving at the facility until Resident A told med tech Chrissy on day shift, and Chrissy notified Ms. Parker. Ms. Parker said Ms. Hudson responded to the fire department's arrival and took them to Resident A's room. Ms. Parker explained that Ms. Hudson reported not knowing of Resident A's call-alert because she was not logged into the facility's tablet that staff are expected to carry.

On 4/7, 4/8 and 4/9/21, administrator Jeffrey Madak provided various documentation including of the facility's call alert response times. The documentation indicated Resident A pressed her call-alert pendant 3/21/21 at 1:50:39 am to notify staff of her need for assistance. The "Resolve" time is when the staff enter the resident's room and turn off the call-alert. The documentation revealed a staff response time of 3 hours 2 minutes and 55 seconds which would have been approximately 4:52 am. This was the early morning when the fire department arrived at the facility.

The documentation also indicates the pull switch at the main entrance was pulled at 4:33:02 am and at 4:37:05 am with "resolve" times of 2 seconds each.

Mr. Madak said he was aware of the extended staff response times and that he has been working on this with staff. Mr. Madak said the expectation is that the staff response time to be under five minutes.

Mr. Madak when he began working at the facility back in October 2020, he assumed the knox box contained the appropriate keys for emergency responders. Mr. Madak

said he met the Northville Twp. EMS Coordinator William Caruso back when he began employment and provided his personal phone number to him. Mr. Madak said he believed Mr. Caruso provided his phone number to first responders. Mr. Madak said the facility's maintenance staff Olaf Walters changed the code on the entrance door key pads for security because families had obtained the code, but he did not know when this change was made.

On 4/8/21, I interviewed Northville Township EMS Coordinator William Caruso by telephone. Mr. Caruso explained that he visits assisted living facilities within his catchment area. Mr. Caruso affirmed that he obtained Mr. Madak's phone number. Mr. Caruso said he had the phone number in order to communicate about Covid positive cases in the facility, but said he had no conversation with Mr. Madak about his personal phone number being made available for emergency purposes.

On 4/7/21, I interviewed Resident A in her room. Resident A explained that she uses her call-alert device to contact staff for assistance as needed, including when she needs to use the bathroom. Resident A also demonstrated that she has an "Alexa" device in her room. She can ask "Alexa" to call her family when staff do not respond to her call pendant, as she did the early morning hours of 3/21/21. Resident A said this was not the first time that she had contacted her family because staff do not respond.

On 4/7/21, Relative A1 was present during my interview with Resident A. Relative A1 explained that Resident A does not want to void in her briefs. She knows when she needs to use the restroom and she calls for staff assistance to be taken to the bathroom. Resident A agreed with this.

On 4/8/21 and 4/12/21, I left voice mails for LaQuarius "Q" Hudson requesting an interview. To date of this report, she has not responded.

On 4/9/21, upon request, Mr. Madak emailed that the facility had 35 residents within the three floors of the assisted living area and 15 residents in the first-floor memory care area of the home during midnight shift of 3/20-3/21/21.

On 4/13/21, I received a call from EMS Coordinator William Caruso. Mr. Caruso said he located the 3/21/21 audio/telephone recordings between first responders and dispatcher at the police department. Mr. Caruso said it revealed at 4:20 am dispatch was called by Resident A's family. Dispatch called the facility at least four times and just got a recording. Mr. Caruso played one of the calls that voice mail says thank you for calling. Please hold and someone will be with you. Then the phone just rings and rings. Mr. Caruso said the audio indicates he fire fighters arrived on site at 4:28 am and they contact with someone in the building at 4:43 am, 15 minutes after arrival, 23 minutes after dispatch first received the call and had been calling the facility without answer.

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.**
For reference: R 325.1901	**Definitions.**
	(16) "Protection" means the continual responsibility of the home to take reasonable action to ensure the health, safety, and well-being of a resident as indicated in the resident's service plan, including protection from physical harm, humiliation, intimidation, and social, moral, financial, and personal exploitation while on the premises, while under the supervision of the home or an agent or employee of the home, or when the resident's service plan states that the resident needs continuous supervision.
ANALYSIS:	The owner, operator, governing body of the home did not assure an organized program of protection for residents. On midnight shift of 3/20-3/21/21, only two staff reported for duty for a three-floor facility with two separate units and 50 residents in the home. For three hours, staff did not respond to Resident A's 1:50 am call for assistance. It necessitated Resident A to notify her family, who in turn contacted the local fire department, to go to Resident A's room with facility staff. There, the fire fighters observed Resident A yelling and with her door open. Fire fighter Kyle Lewis reported Resident A requested assistance getting to the restroom and changing her soaked brief. In addition, upon arrival on 3/21/21, the fire fighters were not able to get staff attention nor gain access to the building for approximately 15 minutes. The facility phone was not being answered after multiple calls, the intercoms were not being answered, the number codes for keypads to unlock entrance doors were not working, hard keys and access cards in the knox boxes also did not function. Only when the fire fighters decided to force entry did the staff respond and allow entrance into the building.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A did not receive care in accordance with her service plan.

INVESTIGATION:

Resident A is 90 years old. Her service plan dated 3/8/21 indicated she has macular degeneration and has become "almost blind", is hard of hearing, and she has limited mobility due to pain and construction of her joints. She requires one person to assist with transferring from her bed to chair and she requires escorts using her wheelchair for mobility/ambulation. The service plan also indicates Resident A wears adult briefs, but she knows when she needs to use the rest room and "I do best with a strictly followed bathroom routine". The nature of this routine is not explained in the plan.

Midnight shift (11 pm to 7:30 am) weekend documentation revealed extended response times to Resident A's call-alert device as follows:

3/14/21 Resident A at 4:46:26 am response time 45 minutes 28 seconds

3/19/21 Resident A at 2:15:19 am response time 51 minutes and 32 seconds

3/20/21 Resident A at 3:04:37 am response time 2 hours 34 minutes 15 seconds

3/21/21 Resident A at 1:50:39 am response time 3 hours 2 minutes and 55 seconds

3/21/21 Resident A at 7:22:09 am response time 23 minutes 16 seconds

3/28/21 Resident A at 3:56:40 am response time 1 hour 23 minutes 15 seconds

Mr. Lewis wrote in his email to Mr. Hughes that on 3/21/21 he and his co-worker Mr. Kolinski, along with the police that responded, had staff guide them to Resident A's room where they found the resident's door open and her yelling for help. The resident requested assistance getting to the restroom and changing her soaked brief. Staff then assisted her.

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.
For reference: R 325.1901	**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:	Resident A relies on staff to assist her with transfer, toileting and other personal needs. She summons staff assistance for these needs via her call alert device. Documentation revealed staff's repeated delay in responses to Resident A's call-alert device, examples ranging from 23 minutes to three hours, when she is summoning staff assistance for personal care, confirms Resident A is not treated with dignity and her personal needs are not attended to consistent with her service plan.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED [Reference: Special Investigation Report (SIR) #2021A1026012 with corrective action plan (CAP) dated 3/31/21; and SIR #2020A0585061 with CAP dated 11/20/20 received on 12/9/20]**

ALLEGATION:

The facility is short staffed.

INVESTIGATION:

This facility has a three-floor assisted living area and a separate 1st floor secured memory care unit. Mr. Madak affirmed that staff on one floor would not be able to see or hear residents on another floor. Also, staff in the assisted living area would not be able to see or hear the residents in the memory care unit and vice versa.

The facility's staffing schedule indicates for every day, afternoon, and midnight shift there is to be one care manager and one medication technician on each of the three floors in the assisted living area. Also, there are to be three care managers and a medication manager on the memory care unit. This would be a total of 10 staff on each shift. However, review of a few staff schedules revealed this staffing level is not being fulfilled.

On the 3/20/21 day shift schedule, staff Donnie's and Angel's names appear on multiple lines, as if additional staff were present to fill all positions. I confirmed with Ms. Parker that Donnie and Angel were the same two individuals just written on multiple lines. Ms. Parker said that means Donnie and Angel covered multiple

floors. Also, some lines were left blank when there was no staff to fill those positions. For 3/20/21 the schedule revealed 8 of 10 staff on duty day shift; 9 of 10 staff on duty for afternoon shift, and only two of 10 staff on duty for midnight shift.

The 3/21/21 staff schedule revealed 7 staff on day shift; 7 staff on afternoon shift and 2 staff on shift from 11 pm to 3 am when a third staff joined them to finish the shift.

The 4/5/21 staff schedule revealed 9 staff on duty day shift with one staff arriving an hour late; 10 staff on duty afternoon shift but two worked only part of the shift from 3 pm to 7:30 pm leaving 8 staff on duty 7:30 to 11 pm; and three staff on duty midnight shift.

Mr. Madak affirmed that the facility does not have sufficient staff hired to meet all scheduled positions dates/times. Mr. Madak explained that current staff cover the shifts by working double shifts, coming in early and/or working late. At times Ms. Parker comes in to cover shifts. Mr. Madak affirmed that at times the schedule is not completely full as expected, and said he is working on contracting with a staffing agency.

A random review of response time documentation revealed extended response times have occurred as follows:

3/14/21 Resident B at 4:30:17 am response time 40 minutes 5 seconds
Resident A at 4:46:26 am response time 45 minutes 28 seconds
Resident C at 7:58:41 am response time 4 hours 46 seconds

3/19/21 Resident A at 2:15:19 am response time 51 minutes and 32 seconds

3/20/21 Resident A at 3:04:37 am response time 2 hours 34 minutes 15 seconds

3/21/21 Resident A at 1:50:39 am response time 3 hours 2 minutes and 55 seconds
Resident A at 7:22:09 am response time 23 minutes 16 seconds

3/26/21 Resident D 6:50:30 am response time 1 hour 40 minutes 54 seconds

3/27/21 Resident E 7:25:23 am response time 26 minutes 19 seconds

3/28/21 Resident A 3:56:40 am response time 1 hour 23 minutes 15 seconds

4/2/21 Resident F 7:10:11 am response time 30 minutes 6 seconds
Resident G 7:29:13 am response time 35 minutes 31 seconds

4/3/21 Resident E 12:59:23 am response time 24 minutes 7 seconds
Resident H 6:41:19 am response time 21 minutes 5 seconds
Resident I 7:06:53 am response time 1 hour 26 minutes 24 seconds

4/4/21 Resident J 3:27:59 am response time 2 hours 53 minutes 45 seconds
Residents B & K 5:19:02 am response time 22 minutes 39 seconds
Resident B 6:38:39 am response time 39 minutes 46 seconds

4/5/21 Resident G 7:20:22 am response time 1 hour 14 minutes 18 seconds
Resident M 9:00:13 am response time 47 minutes 56 seconds
Resident N 7:19:26 pm response time 56 minutes 25 seconds
Resident I 7:35:07 pm response time 1 hour 41 minutes 18 seconds
Resident O 8:13:59 pm response time 34 minutes 58 seconds
Resident A 8:23:34 pm response time 50 minutes 10 seconds
Resident I 9:52:44 pm response time 43 minutes 35 seconds

It is to be noted that the above residents' rooms are located in various areas of the building including each floor of the assisted living and the memory care unit. The various times range over all three shifts.

Also, on 4/5/21 the documentation revealed a visitor was calling at the "ALMC Doorbell" at 9:51 am and the response time was 22 minutes and 4 seconds.

Mr. Madak acknowledged the continuing extended call-alert response times as documented and that the facility sustained a previous licensing violation of extended response times in special investigation report (SIR) #2020A0585061. In response to that violation, the facility's corrective action plan dated 11/20/20, was received and approved on 12/9/20. It indicated by 11/30/20 the call light report would be reviewed weekly and an in-service conducted with staff with an expectation of response times of 5 minutes or less. There would be review at stand-up meetings of any times in excess of 5 minutes and staffing reviewed to ensure adequacy. There was also a job posting for medication managers and care managers. Mr. Madak said all of these corrective measures have been taking place.

The facility's director of health and wellness Laura Kujawski described the facility's staffing schedule differently than what the written schedule indicated. Given the facility's acuity level, Ms. Kujawski explained that in addition to administrative staff, the facility would need to fill five and a half positions on day shift; five and a half positions on afternoon shift; and four positions on midnight shift with an additional supervising nurse on midnight shift from Monday to Friday. A half position means the individual worked 4 hours of the 8 hour shift. All total, this results 16 staff positions a day Monday to Friday, and 15 staff on weekends. Ms. Kujawski explained how difficult it has been in hiring staff during the pandemic.

Reviewing the facility's current roster of 50 residents, Ms. Kujawski identified 16 residents requiring staff assistance with transferring and mobility: Five on first floor assisted living area [Residents O, H, P, Q, R], three on second floor [Residents S, K, F], three on third floor [Residents A, L, T] and three in the memory care unit [Residents U, V, W]. Of these, Ms. Kujawski said three require two-person assist

with transfers [Residents H, R, U]. Ms. Kujawski identified eight residents requiring "total care" [Residents H, R, K, A, L, U, I, X] then clarified, some of these can feed themselves, but staff provide for all other care needs. Ms. Kujawski said two residents in memory care are a safety risk for falls and/or exit seeking as they wander about [Resident C and J]. Ms. Kujawski said 19 residents are fairly independent, although the staff maintain and administer medications to all residents. Other residents require cues, reminders, directions and some assistance with care, Resident V is receiving end-stage hospice care.

Ms. Kujawski said there was a problem with residents receiving two showers a week, but she has addressed this with more specific documentation by staff and paring it with resident laundry days. Ms. Kujawski said there are times when showers have to be moved to the next day, especially when staff call off-duty, but said the residents are receiving assistance with two showers a week.

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:	The facility has 50 residents residing among three separate floors and two separate units. Resident needs vary from fairly independent only needing medication management to requiring "total assistance". Staff schedules are not filled as expected. In addition, there are excessive response times on all three shifts for residents in all areas of the home. There were response times that ranged from 21 minutes to four hours and 46 seconds. The facility did not demonstrate compliance with their own standards nor with this rule.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED [Ref: SIR #2020A0585061 and the corrective action plan dated 11/20/20 that was received on 12/9/20]**

ALLEGATION:

Resident A's room door would not latch and posed a fire hazard.

INVESTIGATION:

According to the allegations, on 3/21/21 when the fire department responded to Resident A's room, Resident A requested the door be closed upon their exit. The

complainant wrote that the door would not latch shut and was unable to be secured. The staff were advised that this was a priority maintenance issue causing a fire hazard that needed to be addressed immediately. Mr. Lewis' email to local fire marshal Tom Hughes reiterated the same message.

On 3/23/21, I made a referral to Bureau of Fire Services (BFS) supervisor Larry DeWachter by telephone. On 4/12/21, Mr. DeWachter emailed that BFS inspector Paul Mullett has verified that the door has been repaired.

APPLICABLE RULE	
R 325.1979	**General maintenance and storage.**
	(1) The building, equipment, and furniture shall be kept clean and in good repair.
ANALYSIS:	A resident's room door not only provides security and privacy but an essential fire safety measure in the event of a fire. Resident A's room door would not latch shut and was unable to be secured. The operation of this door is essential not only for the resident occupant but the entire safety of all occupants of the building and without a program of maintenance to address issues like this, places all residents at risk.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

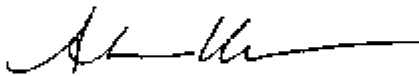
On 3/22/21, the facility's director of health and wellness Laura Kujawski submitted an incident report that indicated a 2 pm meeting was held with Resident A's family, Relative A1 and Relative A2, at the family's request. The report referred to the 3/21/21 incident and read, "The call light was not answered prior to the family being notified by the resident. Family made the decision to call 911 for additional support who arrived shortly after. Upon entering the meeting, the son in law became agitated and upset, raising his voice, and using aggressive body language such as pointing his finger towards writer. Writer became uncomfortable and notified family that the meeting was over due to the aggressive behavior. Writer offered to assist in transferring resident to a community that will meet their expectations. Son in Law continued to use profanity in the hallway and proceeded to resident's room." The report indicates Resident A's authorized representative was present and Resident A's physician assistant Kristi Morris was notified at 3 pm. For corrective measures to prevent recurrence, it is written "Pending follow up at this time".

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, accidents, elopement.**
	(1) The home shall complete a report of all reportable incidents, accidents, and elopements. The incident/accident report shall contain all of the following information: **(a) The name of the person or persons involved in the incident/accident.** **(b) The date, hour, location, and a narrative description of the facts about the incident/accident which indicates its cause, if known.** **(c) The effect of the incident/accident on the person who was involved, the extent of the injuries, if known, and if medical treatment was sought from a qualified health care professional.** **(d) Written documentation of the individuals notified of the incident/accident, along with the time and date.** **(e) The corrective measures taken to prevent future incidents/accidents from occurring.**
For reference: R 325.1901	**Definitions.**
	(17) "Reportable incident/accident" means an intentional or unintentional event in which a resident suffers harm or is at risk of more than minimal harm, such as, but not limited to, abuse, neglect, exploitation, or unnatural death.
ANALYSIS:	The facility's 3/22/21 incident report that referred to the 3/21/21 incident lacked sufficient information about Resident A's call-alert not being addressed by staff for three hours, the resulting need for Resident A to notify her family to call the fire department, the staff not answering the phones and intercom upon the fire department's arrival, and the lack of adequate provisions in place for the fire department to gain access to the building in a timely manner, thereby putting Resident A and all residents in the home at risk of more than minimal harm. In addition, the incident report contained no corrective measures to prevent recurrence to address these matters.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 5/5/21, I reviewed the findings of this report with licensee authorized representative Michele Locricchio by telephone. Ms. Locricchio said she has begun addressing the issues and spending time on-site with the administrator. She also notified corporate staff and has solicited the assistance of corporate nurses.

IV. RECOMMENDATION

A Corrective Notice Order is recommended.



5/5/21

Andrea Krausmann — Date
Licensing Staff

Approved By:

5/5/21

Russell B. Misiak — Date
Area Manager