GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

June 17, 2021

Darlene Vernier
Anthology of Troy
3400 Livernois Rd
Troy, MI 48083

RE: License #: AH630398531
Investigation #: 2021A1026026 Anthology of Troy

Dear Ms. Vernier:

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 #:	AH630398531
Investigation #:	2021A1026026
Complaint Receipt Date:	03/02/2021
Investigation Initiation Date:	03/04/2021
Report Due Date:	05/01/2021
Licensee Name:	CA Senior Troy Operator, LLC
Licensee Address:	3400 Livernois Rd Troy, MI 48083
Licensee Telephone #:	(312) 994-1880
Administrator:	Ellen Byrne
Authorized Representative:	Darlene Vernier
Name of Facility:	Anthology of Troy
Facility Address:	3400 Livernois Rd Troy, MI 48083
Facility Telephone #:	(248) 528-8001
Original Issuance Date:	04/29/2020
License Status:	REGULAR
Effective Date:	10/29/2020
Expiration Date:	10/28/2021
Capacity:	103
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A did not receive adequate and appropriate care.	No
Falls are not being appropriately managed or documented.	Yes
The facility does not have sufficient staff on duty.	No
Medications are not properly stored.	Yes
Additional Findings	No

III. METHODOLOGY

03/02/2021	Special Investigation Intake 2021A1026026
03/04/2021	Special Investigation Initiated - Letter Email requesting additional information sent to APS.
03/24/2021	Inspection Completed On-site
06/17/2021	Exit Conference Exit conference conducted with facility AR by telephone.

ALLEGATION:

Resident A did not receive adequate and appropriate care.

INVESTIGATION:

On 3/2/21, licensing staff received a complaint intake that alleged the following:

> [Resident A] moved into the facility in January 2021. He presented with a persistent cough. [Resident A] was coughing as if he had something stuck in his throat. The cough was bad. A staff member tried to go through the chain of command to get help for [Resident A]. Nothing got done. As the concern rose through the ranks, the concern was dismissed. Upper management said nothing could be done because [Resident A] was receiving hospice care. [Resident A]

passed away this morning…There is concern that [Resident A] could have lived longer if he was provided proper care.

The complainant was not interviewed during this investigation, as this complaint was submitted anonymously.

On 3/24/21, an interview was conducted with facility administrator Ellen Byrne and director of health and wellness Nichole Sanday. Ms. Byrne and Ms. Sanday both stated that they have no memory of any staff member voicing concerns pertaining to Resident A's cough.

Resident A's progress notes were reviewed:

- 1/9/21-"Resident admitted to facility…lungs clear…"
- 1/11/21-"…no observation of pain/distress or [shortness of breath] SOB noted…"
- 1/15/21-"…no s/s of any distress, no sob…"
- 1/23/21-"…no s/s of any distress and no sob…"
- 2/9/21-"Writer was checking on the resident because the caregiver told me that he was coughing but the writer did not observed [sic] resident coughing…"
- 2/16/21-"The mobile CXR is in the building to have [chest x-ray] cxr to the resident."
- 2/16/21-"Writer called for CXR result and was negative…"
- 2/22/21-"X ray results showed no pneumothorax, pneumonia, congestion or pleural effusion. Conclusion no acute disease seen."
- 2/27/21-"Writer was informed by staff that resident was not looking good…o2 [oxygen] 90-92…Notified Kim from Heart to heart hospice. Asked for her to come see resident, to bring oxygen to have on hand…"
- 2/27/21-"The oxygen concentrator was brought by the metro medical equipment INC, and the oxygen was started as order 2 l/min PRN for SOB"
- 3/1/21-"…No signs and symptoms of shortness of breath or distress."

Resident A's medication orders were reviewed. It was noted that there was an order dated 2/14/21 for Robitussin DM S-F Cough Syrup with instructions to "Give 1 liquid by mouth PRN". An additional order for Robitussin DM was dated 2/17 with instructions to "Give 10 ml Liquid by mouth 2 times per day, every day at 8:00 AM, 5:00 PM". An order for PRN oxygen was dated 2/27.

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents;**
	(2) The policy describing the rights and responsibilities of patients or residents required under subsection (1) shall include, as a minimum, all of the following:

	(e) A patient or resident is entitled to receive adequate and appropriate care, and to receive, from the appropriate individual within the health facility or agency, information about his or her medical condition, proposed course of treatment, and prospects for recovery, in terms that the patient or resident can understand, unless medically contraindicated as documented in the medical record by the attending physician or a physician's assistant to whom the physician has delegated the performance of medical care services.
ANALYSIS:	Based on a review of Resident A's record and interviews with facility staff, this allegation could not be substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Falls are not being appropriately managed or documented.

INVESTIGATION:

On 3/3/21, licensing staff received a complaint intake that alleged in-part that "Residents fall and incident reports are not completed. Sometimes residents fall and medical care is not sought because too many clients have fallen that month."

Separate interviews were conducted with care manager Naliejah Brown, caregiver/med tech Crystal Thomas, and caregiver Shatina Hadley. All three staff members made similar statements regarding resident falls and their belief that falls within the facility are handled and documented appropriately.

Ms. Byrne stated that falls are not counted or tallied monthly, and that all falls are evaluated, documented, and addressed appropriately.

Incident reports for January and February were reviewed. It was noted that the facility recorded 27 falls in January and 17 falls in February. It was noted that the incident reports contained the name of the individual(s) involved, the date, hour, location, narrative description, the effect of the incident on the individual(s), the extent of injuries, treatment provided/sought, and documentation of the individuals notified.

During the review of the incident reports, it was noted that on several occasions the facility failed to report incidents to the residents' authorized representatives and/or

physicians. It was also noted that on numerous occasions, the facility failed to report incidents to the department.

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, accidents, elopement.**
	(3) The home shall report an incident/accident to the department within 48 hours of the occurrence. The incident or accident shall be immediately reported verbally or in writing to the resident's authorized representative, if any, and the resident's physician.
ANALYSIS:	While the specific allegations that the facility is not treating and documenting resident falls could not be substantiated, it was determined that on occasion the facility failed to report incidents to residents' authorized representatives and/or physicians, and repeatedly failed to report incidents to the department.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The facility does not have sufficient staff on duty.

INVESTIGATION:

On 3/3/21, licensing staff received a complaint intake that alleged in-part that "The facility is short staffed. Sometimes, management will hold meetings that last up to 3 hours leaving 1 person on a floor. They will leave 1 staff member to care for roughly 25-30 residents."

According to Ms. Byrne, care staff meetings occur infrequently and usually last between 30 minutes and one hour. Ms. Byrne stated that during these times some care staff remain on the floor and other ancillary staff assist with monitoring/care to ensure adequate coverage. Ms. Byrne also stated that the staff in these meetings keep their pagers on and have the ability to leave and return to the floor if they are needed.

The statements of Ms. Brown, Ms. Thomas, and Ms. Hadley were consistent with those of Ms. Byrne with regard to staffing levels during care staff meetings.

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:	Based on interviews with facility staff, this allegation could not be substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Medications are not properly stored.

INVESTIGATION:

On 3/3/21, licensing staff received a complaint intake that alleged in-part that "When the state of Michigan comes to audit the facility, medications are hidden all over. The medications are supposed to be kept in a locked medication cart. When the state shows up, they run around and gather up all the medication that is not stored properly and hide it in an office."

Upon entering the facility five medication carts were inspected within 30 minutes. It was noted that medications within the carts were appropriately stored. No staff members were observed gathering/removing medications from the cart or transporting medications through the facility.

During the inspection of the medication carts, it was noted that two tablets of a residents Acetaminophen (500mg) were left unattended on top of the cart while the med tech was in another resident's room.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(5) A home shall take reasonable precautions to ensure or assure that prescription medication is not used by a person other than the resident for whom the medication is prescribed.

ANALYSIS:	While the specific allegation that the facility removes medications from the carts and hides them could not be substantiated, it was determined that prescription medications were left accessible and unattended by staff.
CONCLUSION:	**VIOLATION ESTABLISHED**

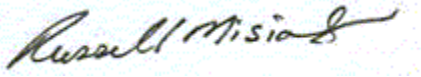
IV. RECOMMENDATION

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

5/4/21

Andrew Schefke Date
Licensing Staff

Approved By:



6/10/21

Russell B. Misiak Date
Area Manager