GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 29, 2021

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

RE: License #: AH820399661
Investigation #: 2021A0784039
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 (810) 787-7031.

Sincerely,

Aaron L Clum

Aaron Clum, Licensing Staff
Bureau of Community and Health Systems
4809 Clio Road
Flint, MI 48504
(517) 230-2778

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH820399661
Investigation #:	2021A0784039
Complaint Receipt Date:	07/26/2021
Investigation Initiation Date:	07/26/2021
Report Due Date:	08/25/2021
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?
Resident A’s contract was not honored	Yes
Additional Findings	No

III. METHODOLOGY

07/26/2021	Special Investigation Intake 2021A0784039
07/26/2021	Special Investigation Initiated - Face to Face Onsite inspection
07/26/2021	Inspection Completed On-site
07/26/2021	Inspection Completed-BCAL Sub. Compliance
07/28/2021	Contact - Telephone call made Interview conducted with sales counselor Alexis Smith
07/28/2021	Contact - Telephone call made Interview conducted with resident care coordinator Jasmine Parker
07/28/2021	Contact - Telephone call made Interview conducted with previous nurse/wellness director Laura Kujawski
07/29/2021	Contact - Telephone call made Interview conducted with complainant.
07/29/2021	Contact – Document Received Resident A's contract recieved by email from Complainant
07/29/2021	Exit Conference – Telephone Conducted with authorized representative Michele Locricchio

ALLEGATION:

Resident A's contract was not honored

INVESTIGATION:

On 7/26/21, the department received this complaint.

According to the complaint, A signed residence contract between Resident A and Anthology of Northville on 7/8/21, with deposit accepted 6/24/21, was broken by the facility immediately prior to the contract move in date. On 6/23/21 Resident A's authorized representative (Resident AR) was given a tour of the facility. On 6/24, Resident AR gave a deposit the facility to secure a bed for Resident A. On 7/5/21, sales counselor Alexis Smith to Resident A's family the state had given clearance for Resident A to move into the facility. On 7/8/21, Ms. Smith presented Resident AR with a Resident contract to be executed on 7/12/21. The Resident contract was signed and agreed upon. On 7/9/21, Ms. Smith left a message with Resident AR stating the facility could not allow Resident A to move in. On 7/10/21, Resident AR spoke with regional sales director Brook Preston who stated she would set up a conference call with administrator Jeff Madak on 7/11/21. On 7/11, Resident AR spoke with Mr. Madak at which time, after much discussion, Mr. Madak informed Resident AR that due to restrictions imposed by the state of Michigan, the facility was not allowed to accept new residents. The facility had not only already signed a contract with Resident AR but had allowed her personal items to be delivered and moved into room 301 at the facility. Several arrangements were made in order to move Resident A into the facility on 7/12/21 due to the miscommunication by the facility which ended up costing Resident A a lot of money and Resident AR a lot of extra time.

On 7/26/21, I interviewed administrator Jeffrey Madak at the facility. Mr. Madak stated that while he was not specifically aware of the tour given to Resident AR on 6/23/21, it is likely the tour was given and done so by sales counselor Alexis Smith. Mr. Madak stated he had not been in communication with Resident AR or any of Resident A's family at that point. Mr. Madak stated that during that time, he had already communicated to his management and sales team that due to a corrective notice order (CNO) issued by the department on 5/24/21, the facility to move in any new residents. Mr. Madak stated that the department had not limited tours of the facility as a part of the CNO. Mr. Madak stated it is also common, and "industry standard", to accept deposits from potential residents in order to hold a spot at the facility. Mr. Madak stated these deposits are fully refundable if the potential resident does not move into the facility and non-refundable if they do move into the facility. Mr. Madak stated he was on vacation from 7/3/21 until 7/13/21, having last worked on 7/2/21 until his return on 7/13. Mr. Mr. Madak stated he did receive a call on approximately 7/9/21 from Ms. Smith inquiring about whether or not the department would allow Resident A an exception to move into the facility. Mr. Madak stated that he, "again", emphatically indicated that no exceptions had

been permitted and no new residents could be accepted at the facility.
Mr. Madak stated he did receive a call from Ms. Preston on approximately 7/10/21, requesting a phone conference with Resident AR on 7/11/21. Mr. Madak stated he spoke with Resident AR on 7/11 and explained that due to actions taken by the department, absolutely no new residents could be admitted to the facility at this time. Mr. Madak stated he did offer to have Resident A move into a sister facility until the CNO was lifted and that Resident AR did not want to do this. Mr. Madak stated he also spoke with Relative A1 who he stated he also conveyed the same information to. Mr. Madak stated he is aware that Ms. Smith wrote up and presented a contract to Resident AR and believed it was signed by Resident AR. Mr. Madak stated is unsure if any representative from the facility signed the contract. Mr. Madak stated he is the only person who is supposed to sign a resident contract unless otherwise instructed. Mr. Madak stated he did not have a copy of the contract as Ms. Smith gave Resident AR the only copy prior to him returning to work on 7/13/21.
Mr. Madak stated that on the day he returned to work, 7/13, he did have a telephone conversation with Relative A1. Mr. Madak stated he gave Relative A1 the deposit back that was given to the facility on 6/24/21. Mr. Madak stated additional funds have also been paid to Resident A due to the extra costs accrued from the mis-communication.

On 7/28/21, I interviewed sales counselor Alexis Smith by telephone. Ms. Smith stated she conducted a tour of the facility with Resident AR on 6/23/21. Ms. Smith stated she had been working with the facility for a short period of time. Ms. Smith stated that it was her understanding that at the time of the tour, the facility was unable to accept new residents due to issues presented by investigations from the department, but that it may be possible to allow new residents to move in soon. Ms. Smith stated that based on the communication from these meetings, she was confident that Resident A would be able to move into the community by 7/12/21, the date ultimately determined for move in during communications with Resident AR. Ms. Smith stated the information she was obtaining regarding this status were from “stand up” meetings with administrative staff which she stated included administrator Jeffrey Madak, nurse Laura Kujawski, and resident care coordinator Jasmine Parker. Ms. Smith stated that during these meetings she was never given a specific directive that the facility could not move residents in or she would not have pursued a completed contract with Resident AR. Ms. Ms. Smith stated that on approximately 6/24/21 or 6/25/21, a relative of Resident A dropped off a deposit check with her at the facility. Ms. Smith stated that the information being communicated to her was never really concrete and that she felt was being “strung along”. Ms. Smith stated that ultimately, she still felt confident enough about the information that she did present a contract with Resident AR on 7/8 at which time she stated she and Resident AR both signed it. Ms. Smith stated she did have the authority to sign a contract with a new admission at that time. Ms. Smith stated Resident AR was also given a set of keys at this time to Room 301, the room Resident A was designated to move into. Ms. Smith stated that at this time, Mr. Madak was on vacation so she communicated the contract signing, on 7/8, with supervisor on duty, nurse Laura Kujawski. Ms. Smith stated that Ms. Kujawski later

came to her, presumably after speaking with Mr. Madak, and told her that the facility is now allowed to move anyone into the facility. Ms. Smith stated she left a message with Resident AR early in the day on 7/9/21 informing her Resident A was not allowed to move into the facility. Ms. Smith stated she received a call from Resident AR later that day who insisted that due to the contract being enacted, Resident A would be moved into the facility. Ms. Smith stated she explained the circumstances to Resident A at that time and that it was not possible for Resident A to move into the facility. Ms. Smith stated that one 7/10/21, after she left work for the day, Resident AR showed up at the facility and unloaded several of Resident A's things into room 301. Ms. Smith stated she found this out as Ms. Parker called her to let her know. Ms. Smith stated it was at this time that regional sales director Brook Preston was informed of the situation. Ms. Smith stated she was not involved in the decision making after this point. Ms. Smith reiterated that she was never given a specific directive not to pursue a new resident admission and that based on the information she was being provided, was confident that by 7/12/21, the facility would be allowed to have Resident A move into the facility. Ms. Smith stated she did not have a copy of the signed contract at the only existing copy was given to Relative A1 when he came to the facility on 7/16/21.

On 7/28/21, I interviewed resident care coordinator Jasmine Parker by telephone. Ms. Parker stated she was not involved in the ongoing communication regarding Resident A and her admission to the community. Ms. Parker stated she was present on 7/10/21 when Resident AR showed up at the facility and started moving Resident A's personal items into room 301. Ms. Parker stated she contacted nurse Laura Kujawski, who she stated was also the health and wellness director, to inform her of what was taking place at that time. Ms. Parker stated it was her understanding that Ms. Kujawski then contacted Ms. Preston to inform her of what was happening. Ms. Parker stated Ms. Kujawski no longer works with the facility. Ms. Parker stated she had been a part of "stand up" meetings referred to by Ms. Smith prior to Mr. Madak's last day before his vacation, 7/2/21. Ms. Parker stated that the departments ban on admissions was discussed during these meetings and that Mr. Madak consistently indicated the facility was not allowed to accept any new residents due to the ban on admissions.

On 7/28/21, I interviewed Laura Kujawski, previous nurse and wellness director, by telephone. Ms. Kujawski stated she was aware of the circumstances surrounding Resident A's admission process. Ms. Kujawski stated she was also aware that the facility was under a CNO and a subsequent admission ban at the time. Ms. Kujawski stated that when the CNO was issued on 5/24/21, the facility was initially going to pursue "fighting" the admission ban. Ms. Kujawski stated that Mr. Madak and facility "department heads", which she stated included supervisors of each department, conducted regular daily meetings at 9:15am. Ms. Kujawski stated that during the weeks after 5/24, at this meetings, Mr. Madak communicated on several occasions that while the facility was under a current admissions ban and could not accept any new residents, it was also possible that the ban might be lifted soon. Ms. Kujawski stated Mr. Madak reported that consultant, Betsy Montgomery,

who had been conducting regular monitoring under the CNO of the facilities activities, had given the impression on several occasions, by way of written and verbal reporting, that she would request a lifting of the admission ban and that it was likely to be lifted. Ms. Kujawski stated that Ms. Smith had expressed, on several occasions, her concern about the facility continuing to give tours and accept deposits for potential residents while not being certain if the admission ban would be lifted. Ms. Kujawski stated Mr. Madak insisted that Ms. Smith continue to allow such actions as he seemed to firmly believe the ban would be lifted. Ms. Kujawski stated that Resident A was essentially the last resident to be given a tour, and to have a deposit excepted for, prior to Mr. Madak giving the directive that no new admissions are going to be allowed and that tours would be discontinued. Ms. Kujawski stated that it is reasonable that Ms. Smith would have pursued the admission of Resident A given the mixed communications being given. Ms. Kujawski stated that while Ms. Montgomery had been providing positive feedback, ultimately HFA consultant Andrea Krausemen visited the facility, related to department CNO monitoring, and found several issues leading to the facility not fighting the CNO. Ms. Kujawski stated her belief that Mr. Madak was encouraging resident touring and acceptance of deposits because he thought the admission ban would be lifted and wanted to have several admissions ready to go.

I reviewed Resident A's *Residency Agreement* provided by Complainant. The agreement included a signature by Resident A's authorized representative as well as sales counselor Alexis Smith.

Review of the facility licensing file confirmed that the facility was issued a CNO on 5/24/21 by the department.

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: **(a) Assume full legal responsibility for the overall conduct and operation of the home.**
For Reference: R 325.1901	**Definitions**
	(19) "Resident admission contract" means a written agreement between the home and the resident and/or the resident's authorized representative that specifies the services to be provided, the fees to be charged, including all fees related to admission such as deposits, admission fees, advance care payments, application fees and all other additional fees, and the home's policies related to the admission and retention of a resident.

ANALYSIS:	The complaint alleged the facility executed a contract with Resident A and immediately rescinded it. The investigation revealed the facility did execute a contract for Resident A and had to rescind the contract due to being under a corrective notice order from the department which explicitly prohibited any new admissions. Based on the findings the allegation is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 7/29/21, I discussed the findings of the investigation with authorized representative Michele Locricchio.

IV. RECOMMENDATION

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

Aaron L Clum 7/29/21

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Aaron Clum Date
Licensing Staff

Approved By:

Russell Misiak 7/29/21

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Russell B. Misiak Date
Area Manager