GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 19, 2021

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

RE: License #: AH630398531
Investigation #: 2021A1019048

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. Failure to submit an acceptable corrective action plan will result in disciplinary action. 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 authorized representative and a date.

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,

Elizabeth Gregory-Weil, Licensing Staff
Bureau of Community and Health Systems
51111 Woodward Avenue 4th Floor, Suite 4B
Pontiac, MI 48342
(810) 347-5503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630398531
Investigation #:	2021A1019048
Complaint Receipt Date:	08/09/2021
Investigation Initiation Date:	08/09/2021
Report Due Date:	10/08/2021
Licensee Name:	CA Senior Troy Operator, LLC
Licensee Address:	3400 Livernois Rd Troy, MI 48083
Licensee Telephone #:	(312) 994-1880
Administrator and 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?
Improper discharge of a resident	No
Additional Findings	Yes

III. METHODOLOGY

08/09/2021	Special Investigation Intake 2021A1019048
08/09/2021	Special Investigation Initiated - Letter Emailed AR requesting copy of discharge notice provided to resident
08/09/2021	Contact - Document Received Discharge notice received via email from AR
08/12/2021	Contact - Document Sent Emailed AR requesting copy of resident's admission contract, service plan and facility discharge policy
08/12/2021	Contact - Document Received Requested documentation received via email from AR
08/12/2021	Contact - Telephone call made Phone call held with AR to obtain additional information. Awaiting follow up documentation.
08/13/2021	Contact - Document Received Chart notes received via email from AR
08/13/2021	Inspection Completed-BCAL Sub. Compliance
08/17/2021	Exit Conference

ALLEGATION:

Improper discharge of a resident

INVESTIGATION:

On 7/30/21, authorized representative Darlene Vernier provided a less than 30 day discharge notification to Relative A (Resident A's power of attorney). Per Ms. Vernier, the facility was no longer able to safely manage Resident A's unpredictable and sometimes violent outbursts. Ms. Vernier stated that the facility located alternative placement for Resident A but that Relative A refused to move Resident A. Ms. Vernier stated that Resident A became increasingly unpredictable in his behavior in the last two months and that staff were fearful of him. Ms. Vernier stated that Resident A has made physical threats against staff and residents and has "gone after staff" on more than one occasion. Ms. Vernier stated that she is unclear why Relative A is not cooperating with the discharge notice, as she reported that she had already notified Relative A that discharge was eminent if issues continued to arise. Ms. Vernier stated that she made the decision to execute the discharge following an outburst that occurred on 7/30/21. On 8/5/21, legal counsel for Resident and Relative A submitted a request for an appeal of the discharge, as they believe that Resident A is not a threat and should be given "another chance". Ms. Vernier stated that Resident A still remains at the facility under one on one supervision until a hearing for the appeal is scheduled.

Incident reports were reviewed pertaining to Resident A. On 6/24/21, an incident report read in part:

> Memory Care resident [Resident A] was observed by care staff to be displaying aggressive behavior. [Resident A] was witnessed pushing a dining room chair, yelling and using profanity. Staff attempted several times to redirect resident but were unable.

On 7/11/21, an incident report read in part:

> Memory Care resident [Resident A] displayed aggressive behavior toward staff member Markaira George. Markaira was in the hallway when she came upon the resident. Markaira went to ask the resident whether he had taken a gallon of milk from the dining room. the resident became upset when Markaira indicated if he had taken the milk. She was going to call his daughter to inform her he needed more for his apartment. Markaira stated that [Resident A] got up from his wheelchair, swinging at her chest and grabbed at her name badge and shirt.

On 7/16/21, an incident report read in part "Memory Care resident [Resident A] was observed in the dining room charging after caregiver yelling profanities and racial slurs. Resident was threatening to 'hit and kill' the caregiver. [Resident A] was not redirectable."

Progress notes were reviewed pertaining to Resident A. On 11/4/20, staff documented “Resident gets mad and aggressive with our residents and dr. Deol contacted about that and she wanted to be watched”. On 1/27/21, staff documented:

> Writer went to do an assessment on resident. Writer went to do vital on resident. Resident was screaming extremely loud with profanity about his right of stating in his room. writer explained to resident about staying in quarantine for 7 days after that he can come out. Resident stated, “I cant be locked up for 7 days”. Resident was extremely upset and said he will not stay in the room and he does not care. Resident was getting combative and would not let writer touch him to do his skin assessment. Supervisor went to residents room to calm him down and explain to the resident to stay in quarantine. Resident got really upset and pinned the supervisor against the wall and was getting aggressive. 911 was called immediately to take resident to the hospital.

On 7/30/21, staff documented “Writer was called when [Resident A] got upset when [Resident B] ate his gardened tomatoes. [Resident A] stood up and started yelling profanity at [Resident B]. [Resident A] threatened to kill [Resident B].” On 7/30/21, staff documented “Called daughter to discuss behaviors [Resident A] displayed today. Explained we will need to move forward with discharge as discussed in previous conversations. Daughter will come to building to discuss.” On 7/30/21, staff documented “Daughter came to community but refused to speak with Darlene Vernier or Shelby Sims. 7 day NOID [notice of involuntary discharge] was emailed to daughter. State of Michigan Licensing was contacted by phone and email.”

Ms. Vernier stated that incidents have continued to occur even with the one on one supervision in place and stated that she plans to provide another less than thirty day discharge notice to Relative A, which will give them 72 hours to move Resident A out. Ms. Vernier also provided additional documentation that outlined aggressive behaviors on 8/7/21 (verbally threatened another resident), 8/8/21 (jumped at caregiver and used profanity towards them) and on 8/9/21 (chased after staff members and used profanity towards them).

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(15) A home may discharge a resident before the 30-day notice if the home has determined and documented that either, or both, of the following exist: **(a) Substantial risk to the resident due to the inability of the home to meet the resident's needs or due to the inability of the home to assure the safety and well-being of the resident, other residents, visitors, or staff of the home.**

	(b) A substantial risk or an occurrence of the destruction of property.
ANALYSIS:	Facility administration deem that they are unable to safely manage Resident A's unpredictable behavior and state he is a physical danger to staff and residents. Incident reports and progress notes support that Resident A had made threats towards both staff and residents and that Resident A has attempted physical harm on staff. Based on this information, the allegation is not substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 7/30/21, Ms. Vernier issued a discharge notice to Relative A citing the reason for discharge as "The health of the individuals in the facility is endangered due to the clinical and/or behavioral status of the resident." The notification letter provided to Relative A outlined an appeal process for the discharge, however home for the aged licensing does not offer an appeal to discharges and the licensee gave false information to Relative A.

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.**
ANALYSIS:	The licensee did not ensure accurate information was provided to Relative A for a less than 30 day discharge issued.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 8/17/21, I shared the findings of this report with authorized representative Darlene Vernier. Ms. Vernier did not have any questions on the above citation.

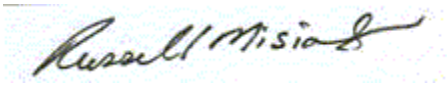
IV. RECOMMENDATION

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

8/17/21

Elizabeth Gregory-Weil Date
Licensing Staff

Approved By:



8/16/21

Russell B. Misiak Date
Area Manager

ADDENDUM TO SPECIAL INVESTIGATION REPORT (SIR) 2021A1019048

ADDITIONAL FINDINGS:

INVESTIGATION:

On 8/16/21, Ms. Vernier issued a second discharge notice to Relative A and provided licensing staff with the revised notification on 8/17/21. Review of the notification revealed that the incorrect information pertaining to filing an appeal was removed, however it did not provide the specific nature of the risk to justify the discharge or identify the alternatives to discharge that the facility has attempted. During a phone call with Ms. Vernier on 8/17/21, she acknowledged that she did not provide a verbal notification of the second discharge as this rule outlines.

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(16) A home that proposes to discharge a resident for any of the reasons listed in subrule (15) of this rule shall take all of the following steps before discharging the resident: **(a) The home shall notify the resident, the resident's authorized representative, if any, and the agency responsible for the resident's placement, if any, not less than 24 hours before discharge. The notice shall be verbal and issued in writing. The notice of discharge shall include all of the following information:** **(i) The reason for the proposed discharge, including the specific nature of the substantial risk.** **(ii) The alternatives to discharge that have been attempted by the home, if any.** **(iii) The location to which the resident will be discharged.** **(iv) The right of the resident to file a complaint with the department.**
ANALYSIS:	The licensee omitted required information in Resident A's discharge notice.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 8/19/21, the addendum was shared with authorized representative Darlene Vernier.

RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan for R 325.1921 (1)(a) and R 325.1922(16), I recommend the status of the license remain unchanged.

8/19/21

Elizabeth Gregory-Weil Date
Licensing Staff

Approved By:

8/19/21

Russell B. Misiak Date
Area Manager