GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 13, 2021

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

RE: License #: AH630398531
Investigation #: 2021A1019053

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
4th Floor, Suite 4B
51111 Woodward Avenue
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 #:	2021A1019053
Complaint Receipt Date:	08/27/2021
Investigation Initiation Date:	08/30/2021
Report Due Date:	10/26/2021
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?
Residents are not receiving medications as prescribed.	Yes
Additional Findings	Yes

III. METHODOLOGY

08/27/2021	Special Investigation Intake 2021A1019053
08/30/2021	Special Investigation Initiated - Letter Emailed AR for additional information.
08/30/2021	Comment Complaint was forwarded to LARA from APS, APS denied the referral and did not assign it for investigation.
08/31/2021	Inspection Completed On-site
08/31/2021	Inspection Completed BCAL Sub. Compliance
09/13/2021	Exit Conference

ALLEGATION:

Residents are not receiving medications as prescribed.

INVESTIGATION:

On 8/27/21, the department received a complaint alleging that Resident B and others are not receiving their medications or are given the wrong medications. The complaint did not provide any dates or names of additional residents not receiving medications correctly.

On 8/31/21, I conducted an onsite inspection at the facility. I interviewed administrator and authorized representative Darlene Vernier, director of health and wellness Valerie Koczara and director of virtue Shelby Sims at the facility. Ms.

Vernier and Ms. Koczara stated that the facility recently has undergone an ‘internal cleanup”, which entails a full review of their medication protocol, retraining of all med passing staff and medication cart reviews by their contracted pharmacy, Omnicare. Ms. Vernier, Ms. Koczara and Ms. Sims stated that staff are trained to report any medication errors and that the errors would be documented, reported to the physician and licensing staff would be notified if the resident suffered more than minimal harm. Ms. Vernier, Ms. Koczara and Ms. Sims denied knowledge of any recent medication errors and did not have any documentation to support errors had occurred within the last month. Ms. Koczara stated that during their internal review, some medications were found to have duplicate orders, which Ms. Koczara reports have been rectified. Ms. Vernier and Ms. Koczara also reported that during their review, one narcotic count was noted to be off by one pill, however upon further review it was discovered that a medication tech had forgotten to sign the medication out and it was successfully accounted for. Ms. Vernier and Ms. Koczara stated that the employee responsible has since been terminated for not following procedure.

Ms. Vernier, Ms. Koczara and Ms. Sims explained that the facility has a two hour window for passing medication (up to one hour before and up to one hour after the scheduled medication time). Ms. Vernier, Ms. Koczara and Ms. Sims stated that staff are to document the medication administrations in real time as they pass the medications and should not be going back later to document. Ms. Vernier, Ms. Koczara and Ms. Sims stated that staff are always to document a reason that a medication is missed and stated that the records should never be blank. Ms. Sims stated that if a medication record is blank, it is assumed that the medication was not administered.

While onsite, medication administration records (MAR) were requested for Residents B, C, D, E and F for July and August 2021. On the following dates, Resident B missed one or more doses of scheduled medication: 7/7/21, 7/11/21, 7/12/21, 7/13/21, 7/14/21, 7/15/21, 7/16/21, 7/17/21, 7/20/21, 7/25/21, 7/31/21, 8/8/21, 8/10/21, 8/14/21, 8/19/21, 8/20/21, 8/24/21 and 8/26/21. On the following dates, Resident C missed one or more doses of scheduled medication: 7/12/21, 7/13/21, 7/14/21, 7/15/21, 7/16/21, 8/2/21, 8/7/21, 8/8/21, 8/10/21, 8/11/21, 8/17/21, 8/20/21, 8/22/21, 8/24/21, 8/27/21, 8/28/21 and 8/30/21. On the following dates, Resident D missed one or more doses of scheduled medication: 7/28/21, 8/1/21, 8/8/21 and 8/12/21. On the following dates, Resident E missed one or more doses of scheduled medication: 7/16/21, 7/20/21, 7/24/21, 7/28/21, 8/7/21, 8/8/21, 8/20/21 and 8/28/21. On the following dates, Resident F missed one or more doses of scheduled medication: 7/2/21, 7/3/21, 7/4/21, 7/6/21, 7/8/21, 7/9/21, 7/10/21, 7/11/21, 7/12/21, 7/14/21, 7/15/21, 7/16/21, 7/17/21, 7/18/21, 7/19/21, 7/24/21, 7/25/21, 7/26/21, 7/27/21, 7/29/21, 7/31/21, 8/2/21, 8/5/21, 8/6/21, 8/7/21, 8/8/21, 8/9/21, 8/11/21, 8/13/21, 8/16/21, 8/17/21, 8/18/21, 8/19/21, 8/20/21, 8/23/21, 8/24/21, 8/25/21, 8/26/21, 8/27/21, 8/28/21 and 8/30/21. For all of the aforementioned dates, the medication administration records were blank for at least one medication/dose, and it could not be verified why the medications were not administered to the residents.

Other medication administration issues were observed in addition to the blank medication administration records. Resident B did not receive her prescribed aspirin from 7/29-8/16/21. Staff repeatedly documented that the medication was reordered but did not follow up with the physician until 8/16/21 to inquire about getting a new prescription. Ms. Vernier stated that the medication was delivered to the facility on 8/16/21. Staff documented that Resident D missed scheduled doses of omeprazole on 8/17-8/31/21. Staff repeatedly documented that the medication was not on the cart and had been reordered. Despite documenting that the medication was not available, staff also intermittently documented that the medication was administered during the same time frame. Ms. Vernier stated that the medication was not refilled in time in part, due to the family initially providing the medication instead of the facility's contracted pharmacy, so it could not be auto filled. Ms. Vernier considers the intermittent "administrations" as documentation errors since the medication was not onsite. Resident D missed scheduled doses of melatonin on 7/23/21, 7/26/21, 7/29/21, 7/30/21, 7/31/21, 8/2/21, 8/6/21, 8/7/21, 8/13/21-8/18/21, 8/21/21, 8/22/21, 8/28/21 and 8/29/21. Staff documented the reason for the missed doses as the medication not available and had been reordered. Despite documenting that the medication was not available, staff also intermittently documented that the medication was administered to Resident D on 7/24/21, 7/25/21, 7/27/21, 7/28/21, 8/3/21, 8/4/21, 8/5/21, 8/8/21, 8/9/21, 8/10/21, 8/11/21, 8/12/21, 8/19/21, 8/20/21, 8/23/21, 8/24/21, 8/25/21, 8/26/21 and 8/27/21. Ms. Vernier stated that the medication was not refilled in time in part, due to the family initially providing the medication instead of the facility's contracted pharmacy, so it could not be auto filled. Ms. Vernier considers the intermittent "administrations" as documentation errors since the medication was not onsite. Resident D missed scheduled doses of vitamin b-12 from 8/5-8/9/21; the medication was not reordered prior to running out on 8/5/21. Resident E missed scheduled doses of levothyroxine sodium from 7/20-7/24/21. The medication was not reordered prior to running out; documentation provided shows the refill request was made on 7/21/21 and Ms. Vernier stated the medication was delivered to the facility on 7/24/21. Resident F missed scheduled doses of escitalopram oxalate on 8/3-8/8/21, 8/23-8/29/21 and 8/31/21. Despite documenting the medication was not available and had been reordered, staff also intermittently documented that the medication was administered to Resident F on 8/22/21 and 8/30/21. Ms. Vernier stated that the 8/22 and 8/30 administrations were a documentation error, and that the physician was providing a new order on 9/8/21 to be sent to the facility within 24 hours. Additionally, numerous instances of medications being administered late (several hours after the scheduled administration time) were observed.

A licensing file review was conducted. No medication errors were reported within the timeframe reviewed.

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:	Review of medication administration records for five residents reveal numerous instances of medications not given and a lack of documentation to justify the missed doses. Medications were also observed to be given late on multiple occasions throughout the timeframe reviewed.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED [For reference, see licensing study report (LSR) dated 11/20/20, CAP dated 12/9/20]**

ADDITIONAL FINDINGS:

INVESTIGATION:

Ms. Vernier stated that staff are expected to reorder medications when they are down to a seven day supply remaining and that the pharmacy makes deliveries to the facility daily. Ms. Vernier stated that the expected turnaround time for a medication refill is dependent on what time the pharmacy receives the order (cut off time for same day delivery is 4:00pm) and other various factors such as but not limited to needing insurance authorization or requiring a new prescription from the physician. Facility protocol was not followed in the cases listed above involving Residents B, D, E and F. Per Ms. Vernier, many of the issues were a result of “delayed staff communication” and improper documentation.

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:	Facility staff did not follow proper protocol of reordering medications timely, resulting in Residents B, D, E and F missing several doses of medication.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Review of Resident B, C, D, E and F's MAR reveal habitual practices of staff not documenting med passes at the time medications are administered, often charting several hours after the med pass occurred. For example, staff repeatedly would cite exceptions such as "given, missed check off window" and "charted late". This was observed for all five resident records reviewed.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(3) If a home or the home's administrator or direct care staff member supervises the taking of medication by a resident, then the home shall comply with all of the following provisions: **(b) Complete an individual medication log that contains all of the following information:** **(v) The initials of the person who administered the medication, which shall be entered at the time the medication is given.**
ANALYSIS:	Review of medication administration records for five residents reveal numerous instances of staff not documenting the medication pass at the time that medication administration occurred.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED [For reference, see licensing study report (LSR) dated 11/20/20, CAP dated 12/9/20]**

On 9/13/21, I shared the findings of this report with authorized representative Darlene Vernier. Ms. Vernier stated she did not have any additional questions and understood the reasoning for the above citations.

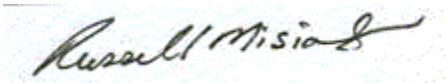
IV. RECOMMENDATION

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

9/10/21

Elizabeth Gregory-Weil Date
Licensing Staff

Approved By:



9/10/21

Russell B. Misiak Date
Area Manager