STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

September 10, 2021

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

RE: License #: AH820399661
Investigation #: 2021A1027048
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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed by the authorized representative and dated.

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. 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 (517) 284-9727.

Sincerely,

Jessica Rogers

Jessica Rogers, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH820399661
Investigation #:	2021A1027048
Complaint Receipt Date:	08/10/2021
Investigation Initiation Date:	08/11/2021
Report Due Date:	10/09/2021
Licensee Name:	CA Senior Northville Operator, LLC
Licensee Address:	44600 Five Mile Rd Northville, MI 48168
Licensee Telephone #:	(312) 994-1880
Authorized Representative/ Administrator:	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:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
A resident left the facility and was not allowed to return.	No
Staff medication administration practices are not safe.	Yes
Additional Findings	No

The complainant alleged the facility was short staffed. Staffing is currently being monitored under a Corrective Notice Order from SIR 20211011023. The complainant alleged the facility did not provide medication training for staff which was investigated in SIR 2021A1019035.

III. METHODOLOGY

08/10/2021	Special Investigation Intake 2021A1027048
08/11/2021	Special Investigation Initiated - Letter Email sent to Administrator J. Madak and AR M. Locricchio to request documentation
08/11/2021	Contact - Telephone call received Voicemail received from administrator J. Madak
08/11/2021	Contact - Telephone call made Telephone interview conducted with administrator J. Madak
09/01/2021	Inspection Completed On-site Staff interviewed and documentation obtained
09/01/2021	Contact - Telephone call made Voicemail left with complainant
09/08/2021	Contact - Telephone call made Voicemail left with Resident A's son
09/08/2021	Contact - Telephone call received Telephone interview conducted with Resident A's son
09/10/2021	Contact - Document Sent

	Email sent to AR/Admin M. Locricchio to request documentation.
09/10/2021	Contact – Document received Email received with requested documentation from M. Locricchio
09/13/2021	Contact – Document Sent Email sent to AR/Admin M. Locricchio to request follow up conference call with facility nurse
09/13/2021	Contact – Telephone call received Telephone conference call conducted with M. Locricchio, facility nurses Jennifer Schuchard and Kayla Meek
09/13/2021	Contact – Document received Email received with requested documentation from M. Locricchio
09/13/2021	Inspection Completed – BCAL Sub. Compliance
09/15/2021	Exit Conference Conducted with authorized representative M. Locricchio

ALLEGATION:

A resident left the facility and was not allowed to return.

INVESTIGATION:

On 8/10/21, the department received a complaint which alleged a resident left the building and was not allowed to return. The complaint did not provide the resident's name.

On 8/11/21, I conducted a telephone interview with former administrator Jeff Madak. Mr. Madak stated a resident was recently transferred from the facility to the hospital and did not return, which was likely the resident referenced in the allegations. Mr. Madak stated Resident A was transferred to the hospital due to a low potassium, then transferred to a skilled rehabilitation center after hospitalization. Mr. Madak stated Resident A required a three person assist and could not use a hoyer lift while at the skilled rehabilitation center. Mr. Madak stated the facility could not meet Resident A's needs due to requiring a higher level of care. Mr. Madak stated he discussed Resident A's care level needs with Resident A's son on 7/24 and explained why the facility could no longer meet her needs. Mr. Madak stated Resident A was placed at another facility upon discharge from skilled rehabilitation center.

On 9/1/21, I conducted an on-site inspection at the facility. I interviewed Resident Care Coordinator LaQuerius Hudson. Ms. Hudson stated her and her colleague Jazmine Parker, who no longer works for the facility, spoke with Resident A's son while he was the facility picking up some of her belongings to take them to the rehabilitation center. Ms. Hudson stated Resident A's son inquired if the facility could manage Resident A after discharge from the rehabilitation center because she required 3-4 person assist and hoyer lift. Ms. Hudson stated prior to transfer to the hospital, Resident A required one to person assist to use her walker to stand then pivot to a wheelchair in which she utilized to transport around the facility. While on-site, I interviewed Resident A's physician Dr. Gary Sarafa. Dr. Sarafa stated Resident A had been declining in her ability to complete activities of daily living prior to transfer to the hospital on 7/8. Dr. Sarafa stated he had not evaluated Resident A after that time.

On 9/1/21, I left a voicemail with the complainant with no return call.

On 9/8/21, I conducted a telephone interview with Resident A's son. Resident A's son stated Resident A required a higher level of care while at the rehabilitation center and sometimes would not participate with therapy. Resident A's son stated the facility director stated the facility could not accommodate Resident A's level of care. Resident A's son stated he agreed with Resident A's discharge from the rehabilitation center to another facility.

I reviewed Resident A's facesheet from the skilled rehabilitation center. The facesheet read Resident A was hospitalized from 7/8/21 to 7/14 and admitted to the skilled rehabilitation center on 7/14.

I reviewed Resident A's service plan. Resident A's service plan read consistent with statements from Ms. Hudson.

I reviewed the incident report provided to the department for Resident A's hospitalization. The incident report read Resident A's physician recommend she transfer to the hospital due to an elevated sodium level on 7/8/21. The incident report read Resident A's family was at bedside at the facility and in agreement with the physician's recommendation.

I reviewed the progress notes from the skilled rehabilitation center for Resident A. The progress notes read consistent with statements from Mr. Madak, Ms. Hudson and Resident A's son. The progress notes from occupational therapy on 7/22 read maximum assist three staff for safety and dependent for all self-care, as well as mobility. Progress note from physical therapy on 7/21 read "Bed mob (mobility) supine to sit max (maximum) assist x 2, sit to stand from EOB (edge of bed) to 2WW (wheeled walker) max assist x2." The physical therapy note read Resident A was dependent for transfers. Progress note from 7/19 from physical therapy read "Spoke with (Resident A's) son on the phone in regards to patient requiring increase care upon DC (discharge) secondary to patient is currently at a hoyer level." Additionally,

the note read the physical therapist recommended Resident A's son seek alternative placement to better assist with her current needs. The note read Resident A's son would contact the social worker at the rehabilitation center to coordinate alternative placement.

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(2) The admission policy shall specify all of the following: **(b) That a home shall not accept an individual seeking admission unless the individual's needs can be adequately and appropriately met within the scope of the home's program statement.**
ANALYSIS:	Staff interviews along with review of documentation revealed Resident A's care needs increased after hospitalization and therapy at the skilled rehabilitation center. The skilled rehabilitation center's physical therapy recommended alternative placement for Resident A based on her increased need for care in which Resident A's son agreed and she was discharged to another facility.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Staff medication administration practices are not safe.

INVESTIGATION:

On 8/10/21, the department received a complaint alleging residents have duplicate medication orders and are overdosed. The complaint also alleged that some residents do not receive their medications.

On 9/1/21, I conducted an on-site inspection at the facility. I interviewed Resident Care Coordinator LaQuerius Hudson. Ms. Hudson stated facility staff administer medications as ordered by the physician. Ms. Hudson stated she did not observe residents missing their medications or being overdosed.

On 9/1/21, I left a voicemail with the complainant with no return call.

On 9/10/21, an email correspondence from administrator Michele Locricchio provided clarification of the facility's medication order process. Ms. Locricchio's email read medication orders are either faxed to Omnicare pharmacy or escribed by the healthcare provider directly to Omnicare. Ms. Locricchio's email read once the medication orders are received by pharmacy, the order is processed and entered into electronic medication administration record (eMAR) system. Ms. Locricchio's email read once the orders are processed at the pharmacy, the medication is delivered to the facility either that evening, if Omnicare receives prior to a certain time, or the following day. Ms. Locricchio's email read orders are verified by the nurses once medications are received and placed in the cart for administration.

On 9/13/21, I conducted a telephone call with administrator Michele Locricchio, facility nurses Jennifer Schuchard and Kayla Meek. Both Ms. Meek and Ms. Schuard stated the community nurse ensures the physician medication orders are correctly transcribed onto the medication administration records (MARs).

I reviewed five resident MARs for July and August 2021. Resident D's MAR read Amlodipine Besylate take one tablet by mouth daily, holed for SBP (systolic blood pressure) less than 120. Resident D's MAR read on 7/18 the Amlodipine Besylate was not initialed as given, nor did the MAR read a blood pressure was obtained. Residents D's MAR read Glipizide give one tablet by mouth once daily which was not initialed as given on 7/16 and 7/17. Resident D's MAR read Metformin HCL give one tablet by mouth twice daily which was not initialed as given at 8:00 PM on 7/2, both 8:00 AM and 8:00 PM on 7/3 and at 8:00 AM on 7/4. Resident E's MAR read Furosemide give one tablet by mouth once daily which was ordered 7/1 and was not initialed as given from 7/2 through 7/7. Resident E's MAR read Furosemide give one tablet by mouth once daily which was not initialed as given on 8/7 and 8/8. Resident F's MAR read Phenytoin Sodium Extended give one capsule by mouth three times daily which was not initialed as given at 2:00 PM on 8/13.

I reviewed the physician medication orders for Resident D, E and F. Both Resident D and Resident F's physician medication orders read consistent with their MARs. Resident E's medication orders read Dicyclomine HCL two capsules by mouth one time per day every day, Dicyclomine HCL two capsules by mouth as needed every six hours and Dicyclomine HCL 10 mg one capsule oral two times a day as needed. Resident E's physician medication orders read Dicyclomine 10 mg give two capsules by mouth every eight hours as needed prescribed on 5/12/20 and Dicyclomine 10 mg one capsule two times a day as needed prescribed on 1/12/21 and 2/18/21.

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: R325.1901	**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:	Medications were not consistently given pursuant to the orders by prescribing health care professional. Review of facility documentation revealed staff did not consistently initial when a medication was given. Facility staff did not mark any reason for the missed doses and the MAR's were left blank, therefore, it cannot be confirmed why the medication administration was not completed as scheduled. Additionally, the physician medication orders did not always match with the MAR. These inconsistent practices do not reasonably ensure the protective needs of residents nor comply with medication administration administrative rules.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 9/15/2021, I shared the findings on this report with facility authorized representative Michele Locricchio. Ms. Lorcricchio verbalized understanding of the citation.

IV. RECOMMENDATION

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

Jessica Rogers

9/14/2021

Jessica Rogers　　Date
Licensing Staff

Approved By:

Russell Misiak

9/15/21

Russell B. Misiak　　Date
Area Manager