



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

ORLENE HAWKS  
DIRECTOR

March 27, 2023

Michele Locricchio  
Anthology of Farmington Hills  
30637 W 14 Mile Rd  
Farmington Hills, MI 48334

RE: License #: AH630402476  
Investigation #: 2023A1027039  
Anthology of Farmington Hills

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 authorized representative 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 (517) 241-1970.

Sincerely,

A handwritten signature in cursive script that reads "Jessica Rogers".

Jessica Rogers, Licensing Staff  
Bureau of Community and Health Systems  
611 W. Ottawa Street  
P.O. Box 30664  
Lansing, MI 48909  
(517) 285-7433  
enclosure

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

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	AH630402476
<b>Investigation #:</b>	2023A1027039
<b>Complaint Receipt Date:</b>	02/09/2023
<b>Investigation Initiation Date:</b>	02/13/2023
<b>Report Due Date:</b>	04/11/2023
<b>Licensee Name:</b>	CA Senior Farmington Hills Operator, LLC
<b>Licensee Address:</b>	Suite 2100 130 E Randolph St Chicago, IL 60601
<b>Licensee Telephone #:</b>	(312) 994-1880
<b>Administrator:</b>	Kelleigh Peddy
<b>Authorized Representative:</b>	Michele Locricchio
<b>Name of Facility:</b>	Anthology of Farmington Hills
<b>Facility Address:</b>	30637 W 14 Mile Rd Farmington Hills, MI 48334
<b>Facility Telephone #:</b>	(248) 983-4780
<b>Original Issuance Date:</b>	03/30/2022
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	09/30/2022
<b>Expiration Date:</b>	09/29/2023
<b>Capacity:</b>	120
<b>Program Type:</b>	ALZHEIMERS AGED

**II. ALLEGATION(S)**

	<b>Violation Established?</b>
Resident A lacked care.	Yes
Resident A's medications were not administered as prescribed.	Yes
Staff were not trained.	No
Additional Findings	No

The complainant identified some concerns that were not related to licensing rules and statues for a home for the aged. Therefore, only specific items pertaining to homes of the aged provisions of care were considered for investigation. The following items were that that could be considered under the scope of licensing.

**III. METHODOLOGY**

02/09/2023	Special Investigation Intake 2023A1027039
02/13/2023	Special Investigation Initiated - Letter Email sent to administrator Kelleigh Peddy requesting Resident A's service plan and MARs
02/13/2023	Contact - Document Sent Email sent to complainant informing her the Department received the allegations submitted and would be conducting an investigation.
02/13/2023	Contact - Document Received Email received from Ms. Peddy with requested documentation
03/20/2023	Inspection Completed On-site
03/20/2023	Inspection Completed-BCAL Sub. Compliance
04/19/2023	Exit Conference Conducted by voicemail, then by email with authorized representative Michele Locricchio

**ALLEGATION:**

## **Resident A lacked care.**

### **INVESTIGATION:**

On 2/9/2023, the Department received a complaint through the online complaint system which read Resident A had history of “ALS” (Amyotrophic lateral sclerosis) in which she required two-person assist for care and a Hoyer lift. The complaint read Resident A required repositioning every two hours. The complaint read Resident A admitted to the facility on 11/1/2022. The complaint read Resident A had not received a shower or bed bath. The complaint read Resident A developed a stage one pressure ulcer on her back and tailbone areas from not being turned and repositioned. The complaint read Resident A’s family requested the facility’s medical service provider, however the paperwork was not completed timely and Resident A had uncontrolled anxiety in which she had stated she wanted to kill herself. The complaint alleged staff had poor call light response times or did not respond at all when Resident A summoned staff by using her pendant. The complaint alleged Resident A’s apartment was never vacuumed nor was her bathroom cleaned.

On 3/20/2023, I conducted an on-site inspection at the facility. I interviewed administrator Kelleigh Peddy who stated Resident A admitted with ALS and had a rapid decline after admission to the facility. Ms. Peddy stated Resident A had switched to the facility’s contract licensed health professional shortly after admission due to her need for pain and anxiety control. Ms. Peddy stated Resident A was sometimes very tired and did not want showers Ms. Peddy stated Resident A lacked trunk control. Ms. Peddy stated Resident A received palliative care services initially, then transitioned to hospice services. Ms. Peddy stated after Resident A’s transition to hospice, hospice staff provided showers and her medications. Ms. Peddy stated Resident A’s service plan was frequently updated and changed to ensure her needs were met. Ms. Peddy stated the staff were expected to answer the call lights timely in which they utilized a walkie system if assistance was needed. Ms. Peddy stated the corporate expectation for call light response times was under 12 minutes. Ms. Peddy stated the call light response logs were not always accurate due to staff forgetting to clear the light upon entry to the resident’s room. Ms. Peddy provided the call light response logs for Resident A’s apartment. Ms. Peddy stated Resident A was assigned pendant #1 and Resident A’s spouse was assigned pendant #2. Ms. Peddy stated concerns regarding Resident A’s housekeeping was not brought to her attention. Ms. Peddy stated Resident A’s room was to be cleaned once weekly in which it was a one bedroom and maintained a lot of durable medical equipment. Ms. Peddy stated the facility maintained a cleaning schedule for housekeeping and provided a copy, as well as an apartment cleaning list.

While on-site, I interviewed Employee #1 whose statements were consistent with Ms. Peddy. Employee #1 stated Resident A did not have medications prescribed for anxiety at admission to the facility. Employee #1 stated Resident A had switched licensed health care providers in which she believed a telehealth visit was completed for her to receive services through the visiting provider at the facility. Employee #1

stated showers were completed minimally once weekly or as per the resident's service plan. Employee #1 stated staff frequently used their walkie talkies to communicate if they were assisting a resident and could not answer the call pendant alert. Employee #1 stated call pendant alerts were sent to the iPads, then continued to alert staff after four minutes.

While on-site, Employee #1 provided the shower schedule which read Resident A showers were scheduled twice weekly in the mornings every Tuesday and Thursday. Employee #1 stated staff were to initial when showers were completed. The week of 11/7/2022 shower schedule read staff initialed Resident A received a shower on 11/9/2022. The week of 11/14/2022 and 11/28/2022 shower schedules lacked staff initials. There was not a shower schedule for the week of 11/21/2022.

I reviewed Resident A's admission agreement dated 10/27/2022 and signed by Relative A1.

I reviewed a form titled *Signing up is Easy!* for Legacy Medical Group in Resident A's records which read "[Resident A] Keeping our Dr's." The form was not completed, was not dated nor a signature of person who transcribed the information.

I reviewed a form titled *Consent for Treatment* dated 11/9/2022 and signed by Resident A for authorization of Legacy Medical Group to provide treatment, as well as consent for treatment with use of prescription medications. I reviewed a form titled *Authorization to release/request medical records information* dated 11/9/2022 and signed by Resident A.

I reviewed Resident A's service plan updated on 12/1/2022 which read consistent with complaint, as well as with statements from Ms. Peddy. The plan read in part Resident A was to receive showers Wednesday and Saturday.

I reviewed Resident A's admission physician orders dated 11/1/2022 which were transcribed on a OneCare pharmacy form and read consistent with statements from Employee #1.

I reviewed physician progress notes dated 11/14/2022, 11/21/2022, and 11/30/2022. Note dated 11/14/2022 read in part the assessment was completed to get to know Resident A. Note dated 11/21/2022 read in part Resident A was unable to turn herself in bed and needed a hospital bed to prevent pressure ulcers. Note dated 11/30/2022 read in part Resident A had transitioned to hospice services.

I reviewed physician orders dated 11/29/2022 which read in part for Resident A to admit to Angela hospice. The orders read in part Resident A's diet/activity was as tolerated. The orders read skin/wound care: turn/reposition every two hours and as needed for comfort.

I reviewed the facility's chart notes dated 11/1/2022 through 12/3/2022. Note dated 11/5/2022 read in part staff attempted to shower resident, however Resident A's family felt the shower chair was insufficient and would not work, so the shower was declined. Note dated 11/9/2022 read in part Resident A requested medication for anxiety in which she stated she would kill herself if she did not receive it. The note also read Resident A took her evening medications in which she was calm afterwards and staff were monitoring her safety. Note dated 12/1/2022 read in part hospice would be administering all medications daily. Note dated 12/3/2022 read in part that Resident A had passed away.

I reviewed the call light response logs dated 11/2/2022 through 11/30/2022 provided by Ms. Peddy at the on-site inspection. The logs read there were pendant calls from both Resident A's pendant and pendant #2 assigned to her spouse. The log read the average to-room elapsed time was 30:01 minutes for both pendants.

I reviewed the facility's cleaning schedule which read room 224 would be cleaned on Thursdays. I reviewed the apartment cleaning check list which read housekeeping staff were to clean the living room, bathroom, kitchen, and bedroom(s). The check list read housekeeping staff were to dust, vacuum and clean windows in the living room and bedroom(s). The check list read housekeeping staff were to clean the shower, sink/countertop, toilet, and floor in the bedroom. The check list read housekeeping staff were to clean the sink/countertop, refrigerator, microwave, cabinets, and floor in the kitchen.

<b>APPLICABLE RULE</b>	
<b>R 325.1931</b>	<b>Employees; general provisions.</b>
	<b>(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.</b>
<b>For Reference: R 325.1901</b>	<b>Definitions.</b>
	<b>(p) "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.</b>

<b>ANALYSIS:</b>	Review of Resident A's medical records revealed she had a diagnosis of ALS in which required her to need two person staff assistance with a Hoyer lift and an electric wheelchair for mobility. Review of Resident A's medical records revealed although her service plan was updated, there was lack of documentation of showers. For example, a chart note read staff documented a refusal of a shower on 11/5/2022 and initialed one shower as provided on 11/7/2022 in which there was no other evidence showers were provided. Additionally, Resident A's consent for medical services was signed on 11/9/2022 and first progress note dated 11/14/2022, in which was two weeks from her admission date to the facility. Furthermore, review of the call light response log revealed it was not consistent with the corporate policy. There was insufficient documentation to support Resident A had developed a stage one pressure ulcer or that her apartment had not been cleaned, however, due to the aforementioned information, these allegations were substantiated.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**ALLEGATION:**

**Resident A's medications were not administered as prescribed.**

**INVESTIGATION:**

On 2/9/2023, the Department received a complaint through the online complaint system which read all morning medications were administered from 5:30 AM to 10:00 AM. The complaint read Resident A's medications were crushed without an order. The complaint read staff administered Resident A's medications without ensuring her medications were swallowed. The complaint read staff administered Resident A's prescribed Ativan and Xanax together.

On 3/20/2023, I conducted an on-site inspection at the facility. I interviewed Ms. Peddy who stated the facility had a flexible time medication pass in which staff had a timeframe to administer medications. Ms. Peddy stated the morning medication pass was from 6:00 AM to 10:00 AM, noon medication pass was from 11:00 AM to 2:00 PM, afternoon medication was from 5:00 PM to 9:00 PM and evening medication pass was 9:00 PM to 11:00 PM. Ms. Peddy stated Resident A's medications were administered by staff then once she signed onto hospice services, their staff administered all her medications per Resident A's family request.

While on-site, I interviewed Employee #1 whose statements were consistent with Ms. Peddy. Employee #1 stated Resident A's medications were administered as prescribed. Employee #1 stated she did not recall crushing Resident A's medications, but medications could appear crushed if they dissolved in applesauce. Employee #1 stated medications were delivered in bubble packs from the pharmacy. Employee #1 stated the medication administration process consisted of each shift completing a narcotic count on the medication cart, then reviewing and signing off in "Yardi," the program for medication administration. Employee #1 stated medication technicians took the medication cart to each resident's apartment door in which they followed the physician orders in Yardi for administration. Employee #1 stated medications were placed in the administration cup then provided to the resident. Employee #1 stated staff were to stay with each resident during the administration of their medications.

I reviewed Resident A's admission physician orders dated 11/1/2022 which read consistent with statements from Employee #1. The orders read in part Resident A's list of medications prescribed as well as that she was on a regular diet.

I reviewed a Dysphagia Plan of Care dated 11/22/2022 which read in part Resident A's medications were to be administered whole and one at a time, with yogurt, applesauce, or pudding.

I reviewed Resident A's November 2022 through December 3, 2022 medication administration records (MARs). The MARs read a list of abbreviations were utilized to document the administration of medications. For example, the abbreviation key read staff initials meant the medication was given, "DNG" meant drug not given, "DC" meant discontinued order, "REF" meant resident refused, "HLD" meant medication on hold, and "X" meant self-administered without charting. The November 2022 MAR read Alprazolam (commonly referred to as Xanax) 0.25 mg, take one tablet by mouth twice daily was prescribed and started on 11/15/2022. The November 2022 MAR read Alprazolam was initialed by staff as administered consistent with the order, however the evening dose on 11/25/2022 had a line strike through that dose in which there was not a corresponding reason in the abbreviation key or note as to why it was not administered. The MAR read staff initialed the last dose of Alprazolam during the morning medication pass on 11/30/2022 in which it was stopped after that time. The November 2022 MAR read Lorazepam (commonly referred to as Ativan) 0.5 mg, take one tablet by mouth three times a day around the clock was prescribed and started on 11/30/2022. The MAR read staff initialed the first dose of Lorazepam as administered on 11/30/2022 during evening medication pass. The November 2022 MAR read Lorazepam 0.5 mg, take one tablet by mouth every four hours as needed for anxiety and restlessness which started on 11/30/2022 and there were not as needed doses administered. Additionally, the November 2022 MAR read on 11/25/2022, the evening doses of both prescribed Cephalexin and Hydrocodone-Acetaminophen had a line strike through the dose in which there was not a corresponding reason in the abbreviation key or note as to why it was not administered.



I reviewed the facility's medication technician training forms which read in part staff were to observe the resident swallow the medications.

I reviewed the facility's policy and procedure manual for medication services which read in part all medications that staff members handle, store and assist with will be documented on the MAR.

<b>APPLICABLE RULE</b>	
<b>R 325.1932</b>	<b>Resident medications.</b>
	<b>(2) Prescribed medication managed by the home shall be given, taken, or applied pursuant to labeling instructions, orders and by the prescribing licensed health care professional.</b>
<b>ANALYSIS:</b>	Review of Resident A's medical records revealed facility staff were to administer her medications in November 2022. Review of Resident A's physician orders revealed her medications were to be administered whole in which there was insufficient evidence to support she received them crushed. Employee #1's interview was consistent with medication training forms in which revealed staff were to observe each resident swallow their medications, however there was insufficient evidence to support this allegation. Review of Resident A's MARs revealed Xanax was stopped and Ativan was started on 11/30/2023 in which both were initialed as administered at different times. The MAR read on 11/25/2023, three medications were documented with line strike in which was not in accordance with the abbreviations utilized nor were there notes for these medications, thus it could not be determined if those medications were administered or not. Based on this information, this allegation was substantiated.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**ALLEGATION:**

**Staff were not trained.**

**INVESTIGATION:**

On 2/9/2023, the Department received a complaint through the online complaint system which read Employees #2 and #3 were verbally abrasive. The complaint read staff had unsafe medication administration practices. The complaint read medication technicians could not speak to the medications they were administering.

The complaint read medications were brought to the room opened and unlabeled without a medication sheet. The complaint read staff instructed Resident A to not drop her Xanax because she could not get another one. The complaint read staff were not trained on ALS.

On 3/20/2023, I conducted an on-site inspection at the facility. I interviewed Ms. Peddy who stated Employee #2 was the resident care coordinator and medication technician, however no longer worked for the facility. Ms. Peddy stated she interviewed and educated Employee #2 after she was informed that she instructed Resident A to not drop medication. Ms. Peddy stated Employee #2 stated during her interview that she asked Resident A to be careful with medications in which her statement was misinterpreted. Ms. Peddy stated in addition to initial training completed, staff were to complete on-line training through the *Relias* program.

While on-site, I interviewed Employee #1 whose statements were consistent with Ms. Peddy regarding Employee #2. Employee #1 stated medication training consisted of six-hour class in which a certificate of completion was provided. Employee #1 stated the medication technicians trained three days with a preceptor then completed an observation check off with the nurse or lead medication technician. Employee #1 stated if residents had questions regarding their medications, then she would suggest the medication technicians write down the medications for the resident.

While on-site, I reviewed Employee #2's file which read her start date was 4/13/2022 and her employee termination was voluntary in which her last day worked was 1/18/2023. Employee #2's file maintained a workforce background check dated 4/13/2022 which read she was eligible for employment. Employee #2's file read in part she had received training on 4/14/2022 on the following abuse, reporting requirements and documentation, first aid, personal care, resident rights and responsibilities, safety and fire prevention, containment of infectious disease and standard precautions, and care skill competency. Employee #2's file read she passed the medication administration tested on 5/17/2022.

While on-site, I reviewed Employee #3's file which read her date of hire was 2/25/2022. Employee #3's file maintained two workforce background checks dated 2/9/2022 and 4/14/2022 in which both read she was eligible for employment. Employee #3's file read in part she had received training on 2/25/2022 on the following abuse, reporting requirements and documentation, first aid, personal care, resident rights and responsibilities, safety and fire prevention, containment of infectious disease and standard precautions, and care skill competency. Employee #3's file read she completed medication manager training and passed a medication administration test on 3/8/2022.

While on-site, I reviewed Employee #1's file which read her date of hire was 7/27/2022. Employee #1's file maintained a workforce background check dated 7/22/2022 which read she was eligible for employment. Employee #1's file read in

part she had received training on 7/27/2022 on the following abuse, reporting requirements and documentation, first aid, personal care, resident rights and responsibilities, safety and fire prevention, containment of infectious disease and standard precautions, and care skill competency. Employee #1's file read she completed a medication administration observation pass on 7/27/2022.

While on-site, I observed the 2<sup>nd</sup> floor medication room in which maintained the locked medication cart for that floor. I observed the March 2023 narcotic count sheet was completed each shift. I observed the inside of medication cart was organized by resident room numbers. I observed resident's medications were maintained in blister packs, except for the medications prescribed as powders or liquids.

I reviewed the facility's job qualifications for a medication technician which read medication technician experience, high school diploma or GED (General Educational Development), minimum of one-year experience, ability to work under pressure and relate well to residents, excellent bedside manner, strong organizational skills, and attention to detail, excellent written and verbal communication skills, experience with an electronic health record system, and fluent in English Language.

I reviewed the facility's medication observation pass checklist which read in part medication technicians were observed and evaluated by the nurse initially then every six months thereafter. The checklist read there were 29 items to be observed in which the nurse would document if item was met or not met. The checklist items read in part medications were checked for seven "rights." The checklist items read in part medications were documented, electronically, after each one was punched. The checklist items read in part for the medication technician to observe the resident swallow the pills.

I reviewed the facility's policy and procedure manual for medication services which read in part all medications for residents who received assistance with their medications will be stored in the designated medication storage area of each building.

<b>APPLICABLE RULE</b>	
<b>R 325.1931</b>	<b>Employees; general provisions.</b>
	<p><b>(6) The home shall establish and implement a staff training program based on the home's program statement, the residents service plans, and the needs of employees, such as any of the following:</b></p> <ul style="list-style-type: none"> <li><b>(a) Reporting requirements and documentation.</b></li> <li><b>(b) First aid and/or medication, if any.</b></li> <li><b>(c) Personal care.</b></li> <li><b>(d) Resident rights and responsibilities.</b></li> <li><b>(e) Safety and fire prevention.</b></li> </ul>

	<p><b>(f) Containment of infectious disease and standard precautions.</b></p> <p><b>(g) Medication administration, if applicable.</b></p>
<b>ANALYSIS:</b>	<p>Review of the facility's training program revealed it was consistent with staff attestations. Review of Employees #1, #2, #3's files revealed they received training consistent with this rule as well as were all eligible to work. Additionally, review of employee files revealed abuse training included verbal abuse in which Employee #2 and #3's files lacked disciplinary action in relation to caring for Resident A. Thus, there was insufficient evidence to support these allegations.</p>
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

**IV. RECOMMENDATION**

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

*Jessica Rogers*

03/27/2023

\_\_\_\_\_  
 Jessica Rogers  
 Licensing Staff

\_\_\_\_\_  
 Date

Approved By:

*Andrea Moore*

04/18/2023

\_\_\_\_\_  
 Andrea L. Moore, Manager  
 Long-Term-Care State Licensing Section

\_\_\_\_\_  
 Date