GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

August 31, 2023

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

RE: License #: AH630402476
Investigation #: 2023A1019067

Dear Licensee:

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 (517) 284-9730.

Sincerely,

Elizabeth Gregory-Weil, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 347-5503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630402476
Investigation #:	2023A1019067
Complaint Receipt Date:	08/17/2023
Investigation Initiation Date:	08/18/2023
Report Due Date:	10/16/2023
Licensee Name:	CA Senior Farmington Hills Operator, LLC
Licensee Address:	130 E Randolph St, Suite 2100 Chicago, IL 60601
Licensee Telephone #:	(312) 994-1880
Administrator:	Dolanda Scott
Authorized Representative:	Michele Locricchio
Name of Facility:	Anthology of Farmington Hills
Facility Address:	30637 W 14 Mile Rd Farmington Hills, MI 48334
Facility Telephone #:	(248) 983-4780
Original Issuance Date:	03/30/2022
License Status:	REGULAR
Effective Date:	09/30/2022
Expiration Date:	09/29/2023
Capacity:	120
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A had injuries of unknown origin.	No
Lack of medical treatment following a fall.	Yes
Additional Findings	No

III. METHODOLOGY

08/17/2023	Special Investigation Intake 2023A1019067
08/18/2023	Special Investigation Initiated - Letter APS notification
08/18/2023	APS Referral
08/23/2023	Inspection Completed On-site
08/24/2023	Inspection Completed BCAL Sub. Compliance

ALLEGATION:

Resident A had an injury of unknown origin.

INVESTIGATION:

On 8/16/23, the department received a complaint alleging that in December 2022, it was discovered that Resident A had a broken clavicle. The complaint alleges that facility staff were unaware of the injury and could not provide an explanation of how the injury occurred. Resident A no longer resides at the facility as of May 2023.

On 8/23/23, I conducted an onsite inspection. I interviewed administrator Dolanda Scott and Employee 1 at the facility. Ms. Scott recently began her employment at the facility and had no firsthand knowledge or experience with Resident A, as she had moved out before she began working there. Employee 1 stated that Resident A resided in the memory care unit and was alert and oriented to person only, had difficulty communicating and could only answer very basic questions. Employee 1 stated that Resident A had paralysis on one side of her body, so she required hands

on assistance with most personal care tasks and needed wheelchair escorts for ambulation. Employee 1 stated that Resident A's daughter insisted that she have a call pendant to notify staff when she needed assistance, but that Resident A did not have the cognitive capability to use it. Employee 1 stated that Resident A was a fall risk due to her memory deficits and there were times that she would attempt to ambulate on her own unsuccessfully. Employee 1 recalled that Resident A moved into the facility at the end of November 2022 with an existing injury that she was receiving physical therapy services for at the time but had no recollection of an event to cause additional injury to the resident around the timeframe referenced in the complaint.

While onsite, Ms. Scott reviewed Resident A's past progress note documentation and observed an entry dated 12/6/22 that read "Resident's daughter notified writer of resident having fx to right clavicle after complete mobile X-ray. Resident's daughter states resident has hx of right clavicle fx in the past. Resident's daughter states she will follow up with orthopedic specialist and follow up with writer for plan of care." Ms. Scott was unable to locate any documentation to support any treatment or intervention was completed on Resident A's clavicle following the 12/6 notation. It is unclear who ordered the x-ray or what prompted the need for the x-ray. Review of additional progress note documentation reveals that Resident A moved into the facility on 11/18/22 and most recently had an unwitnessed fall on 11/19/22 where staff documented that there was no injury and Resident A denied experiencing any pain.

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents;**
	(1) A health facility or agency that provides services directly to patients or residents and is licensed under this article shall adopt a policy describing the rights and responsibilities of patients or residents admitted to the health facility or agency. Except for a licensed health maintenance organization, which shall comply with chapter 35 of the insurance code of 1956, 1956 PA 218, MCL 500.3501 to 500.3580, the policy shall be posted at a public place in the health facility or agency and shall be provided to each member of the health facility or agency staff. Patients or residents shall be treated in accordance with the policy.
For Reference MCL 333.20201	**(2) (e) A patient or resident is entitled to receive adequate and appropriate care, and to receive, from the appropriate individual within the health facility or agency, information about his or her medical condition,**

	proposed course of treatment, and prospects for recovery, in terms that the patient or resident can understand, unless medically contraindicated as documented in the medical record by the attending physician, a physician's assistant with whom the physician has a practice agreement, or an advanced practice registered nurse.
ANALYSIS:	Facility staff interviewed onsite were unaware that Resident A sustained a fractured clavicle nine months prior and it was discovered that Resident A had a history of clavicle fracture. Review of progress notes reveal a documented unwitnessed fall 2.5 weeks before discovering the clavicle injury, but there is no evidence to correlate the fall as the direct cause of the injury.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Lack of medical treatment following a fall.

INVESTIGATION:

The complaint alleges that on 5/14/23, Resident A was observed to have a change in condition which prompted her to be hospitalized. At the hospital, it was discovered that Resident A had numerous injuries, including six fractured ribs. The complainant alleges that Resident A had a fall a few days prior, however alleges that facility staff failed to seek medical treatment or provide notification of the fall to Resident A's family.

While onsite, Ms. Scott located incident reports, progress note documentation and staff statements that coincide with the event in the complaint. An incident report authored by the former executive director on 5/20/23 read:

> *At 6:45pm on 5/12/23 [Employee 2] was informed that resident had a fall. She instructed the Medication Technician to obtain vital signs and notify the appropriate parties. Med tech notified daughter, however, her voicemail was full. Baseline cognition is alert and oriented to person only. One person assist with transfers. Resident did not appear to have any injuries at that time. Family was in to visit resident on Sunday after the fall and noticed different breathing patterns. Nurse on duty assessed and sent her to the hospital for further evaluation. Vital signs were normal, however, further evaluation was indicated with LPN assessment. Daughter contacted community on Thursday following the fall to*

notify staff of resident's diagnosis of pneumonia and rib fractures. At that time, investigation of fall occurrence took place.

A second incident report read:

Caregiver was assisting resident to the restroom. While assisting, caregiver stepped away into resident's room in eye contact. When caregiver stepped away, resident attempted to stand on her own and lost her balance which caused resident to fall. Caregiver immediately assisted resident. Med tech was called to assess. Vitals were taken and in normal range. DHW notified. Daughter was called with no answer, not able to leave message due to voicemail being full.

A progress note authored by Employee 3 dated 5/14/23 read:

Resident's daughter had concerns of resident's breathing. Resident was assessed by writer, lung sounds were clear on bil lobes with no SOB noted. Vs will, BP- 108/71, P-89, oxygen sat on RA 96%. Resident was observed having intervals of tensing up while catching a breath. Resident to be send [sic] out to Beaumont Farmington Hills. MD was called to no avail, office was closed. Face sheet and medications list were send [sic] along with resident. 911 was called. Resident left at approximately 1450 with daughter.

A statement authored by Employee 4 read:

I was putting [Resident A] on the toilet and she was then sitting I end up having to throw up so I grab the trash can on the side of [Resident A's] TV before I left I said don't get up [Resident A] but she got up anyway and the mist [sic] up [sic] me throwing up…then I heard a boom! She had a little cut on her hand when I enter the bathroom she was on her back and was making weird noises and her breathing was sounding weird as well I held her head in my hand as I call for help on the walkie no one came so set her up so I can go find help…when I got the med tech she didn't even know what to do so I page [unknown staff] and then she was saying how she bouta [sic] leave @8 or whatever so I'm guessing she didn't feel like explaining to the other med tech what to do when this type of stuff happens however I believe she checked her vitals in [sic] said she was good so me and [unknown staff] put her too [sic] bed the next day I came in I was told she was sent out.

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: **(c) Assure the availability of emergency medical care required by a resident.**

ANALYSIS:	Resident A had a fall on 5/12/23 which resulted in six fractured ribs. Staff failed to follow community protocol and did not seek medical attention when she presented with a change in condition.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

08/24/2023

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Elizabeth Gregory-Weil Date
Licensing Staff

Approved By:

08/31/2023

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