GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 23, 2020

Michele Locricchio
Anthology of Rochester Hills
1775 S. Rochester Rd
Rochester Hills, MI 48307

RE: License #: AH630398529

Dear Ms. Locricchio:

Attached is the Renewal Licensing Study Report for the facility referenced above. The violations cited in the report require the submission of a written corrective action plan. Upon receipt of an acceptable corrective action plan, a regular license will be issued. If you fail to submit an acceptable corrective action plan, disciplinary action will result. 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 dates 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 home for the aged 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 feel free to 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**
**RENEWAL INSPECTION REPORT**

## I. IDENTIFYING INFORMATION

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|---|---|
| **License #:** | AH630398529 |
| | |
| **Licensee Name:** | CA Senior Rochester Hills Operator, LLC |
| | |
| **Licensee Address:** | 1775 S. Rochester Rd<br>Rochester Hills, MI 48307 |
| | |
| **Authorized Representative:** | Michele Locricchio |
| | |
| **Administrator:** | Matthew Cortis |
| | |
| **Name of Facility:** | Anthology of Rochester Hills |
| | |
| **Facility Address:** | 1775 S. Rochester Rd<br>Rochester Hills, MI 48307 |
| | |
| **Facility Telephone #:** | (248) 266-0356 |
| | |
| **Original Issuance Date:** | 05/13/2020 |
| | |
| **Capacity:** | 105 |
| | |
| **Program Type:** | ALZHEIMERS<br>AGED |
| | |

## II. METHODS OF INSPECTION

Date of On-site Inspection(s): 11/20/2020

Date of Bureau of Fire Services Inspection if applicable: 08/03/2020

Inspection Type: ☐ Interview and Observation ☒ Worksheet ☐ Combination

Date of Exit Conference: 11/20/2020

No. of staff interviewed and/or observed 27
No. of residents interviewed and/or observed 36
No. of others interviewed 0 Role

- Medication pass / simulated pass observed? Yes ☒ No ☐ If no, explain.

- Medication(s) and medication records(s) reviewed? Yes ☒ No ☐ If no, explain.
- Resident funds and associated documents reviewed for at least one resident? Yes ☐ No ☒ If no, explain. The facility does not hold resident funds in trust.
- Meal preparation / service observed? Yes ☒ No ☐ If no, explain.

- Fire drills reviewed? Yes ☐ No ☒ If no, explain.
  The Bureau of Fire Services reviews fire drills, however facility disaster planning procedures were reviewed.
- Water temperatures checked? Yes ☒ No ☐ If no, explain.

- Incident report follow-up? Yes ☐ IR date/s: N/A ☒
- Corrective action plan compliance verified? Yes ☐ CAP date/s and rule/s: N/A
- Number of excluded employees followed up? N/A ☒

## III. DESCRIPTION OF FINDINGS & CONCLUSIONS

<table>
<tr><td colspan="2">This facility was found to be in non-compliance with the following rules:</td></tr>
<tr><td>R 325.1921</td><td>Governing bodies, administrators, and supervisors.</td></tr>
<tr><td></td><td>(1) The owner, operator, and governing body of a home shall do all of the following:<br>(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.<br><br>For Reference:<br><br>(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.</td></tr>
<tr><td colspan="2">Resident A was observed to have a device commonly referred to as a “bed assist” or “bed cane”. The bed side assistive device is designed to slide underneath the resident’s mattress. The device was not affixed securely to the bed frame and could slide away from the mattress causing an entrapment area between itself and the mattress. The facility could not produce manufacturer’s guidelines for proper installation and use of the bed side assistive device. Resident A’s record did not have a physician’s order for the assistive device directing its purpose and authorization for use. Resident A’s service plan did not reference the device; thus, staff had no methods to follow regarding their responsibilities related to the device. Facility staff were unaware of any procedure for evaluation, ongoing monitoring, and/or maintenance program to reduce risk of injury or death due to entanglement and/or entrapment within the assistive device. The lack of a reasonably organized program of protection related to these devices places staff at a disadvantage when attempting to meet the safety needs of residents and does not reasonably protect residents from the possibility of unnecessary entrapment and/or entanglement injury or death associated with such devices.</td></tr>
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| **R 325.1922** | **Admission and retention of residents.** |
| | **(1) A home shall have a written resident admission contract, program statement, admission and discharge policy and a resident's service plan for each resident.** |
| The facility underwent a change of ownership that was processed in May 2020, which included a change to the licensee organization. Review of resident admission contracts reveal that not all resident contracts were not updated to reflect the new ownership entity, thus making the contracts between the resident and a limited liability corporation that differs from that of the licensee and “owner” as worded in the contract. | |
| **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:**<br><br>**(b) Complete an individual medication log that contains all of the following information:**<br>**(i) The medication.**<br>**(ii) The dosage.**<br>**(iii) Label instructions for use.**<br>**(iv) Time to be administered.**<br>**(v) The initials of the person who administered the medication, which shall be entered at the time the medication is given.**<br>**(vi) A resident's refusal to accept prescribed medication or procedures.** |
| The facility has not always provided an accurate and complete medication log. Due to administrative restrictions in place with the facility’s electronic medication administration record system, staff are not continually able to document medication administration in real time as outlined in this rule.<br><br>For example, Resident B’s medication administration record (MAR) was blank for his scheduled 8:00pm dose of Gabapentin on 10/15/20 and 10/16/20. Progress notes verified that the medications were given as prescribed, but staff did not document the 10/15/20 administration until 10/16/20 and didn’t document the 10/16/20 administration until 10/19/20. In both instances, staff failed to initial the MAR when medications were given in both instances. Resident B’s MAR was also blank for his scheduled 8:00pm dose of Metoprolol on 11/18/20. A progress note verified that the medication was given as prescribed, but staff did not document the administration in | |

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|---|---|
| the progress note until 11/20/20 and staff failed to initial the MAR at the time of administration.<br><br>Resident C's MAR was blank for her scheduled 8:00pm dose of Apixaban on 11/14/20. Supporting documentation was provided to verify the medication was given on time, however staff failed to initial the MAR at the time of administration. | |
| **R 325.1964** | **Interiors.** |
| | **(9) Ventilation shall be provided throughout the facility in the following manner:**<br><br>**(b) Bathing rooms, beauty shops, toilet rooms, soiled linen rooms, janitor closets, and trash holding rooms shall be provided with a minimum of 10 air changes per hour of continuously operated exhaust ventilation that provide discernable air flow into each of these rooms.** |
| Continuous exhaust ventilation was not functioning properly in most of the areas tested on the second floor of the facility. The director of plant operations Jordan Robison later reported that a broken motor was observed to be the cause of the malfunctioning ventilation. | |
| **R 325.1976** | **Kitchen and dietary.** |
| | **(6) Food and drink used in the home shall be clean and wholesome and shall be manufactured, handled, stored, prepared, transported, and served so as to be safe for human consumption.** |

## IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, renewal of the license is recommended.

11/23/20

Elizabeth Gregory-Weil Date
Licensing Consultant