GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 20, 2021

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

RE: License #: AH630398529
Investigation #: 2021A1026028 Anthology of Rochester 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 responsible party 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 (616) 356-0183.

Sincerely,

Andrew Schefke, Licensing Staff
Bureau of Community and Health Systems
350 Ottawa, N.W.
Grand Rapids, MI 49503
(517) 897-1560

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630398529
Investigation #:	2021A1026028
Complaint Receipt Date:	03/19/2021
Investigation Initiation Date:	03/22/2021
Report Due Date:	04/18/2021
Licensee Name:	CA Senior Rochester Hills Operator, LLC
Licensee Address:	1775 S. Rochester Rd Rochester Hills, MI 48307
Licensee Telephone #:	(248) 266-0356
Administrator:	Matthew Cortis
Authorized Representative:	Michele Locricchio
Name of Facility:	Anthology of Rochester Hills
Facility Address:	1775 S. Rochester Rd Rochester Hills, MI 48307
Facility Telephone #:	(248) 266-0356
Original Issuance Date:	05/13/2020
License Status:	REGULAR
Effective Date:	11/13/2020
Expiration Date:	11/12/2021
Capacity:	105
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Medications were not properly administered to Residents A and B.	Yes
The facility did not meet Resident A's personal care needs.	Yes
Residents A and B's room was not clean.	No
Additional Findings	Yes

III. METHODOLOGY

03/19/2021	Special Investigation Intake 2021A1026028
03/22/2021	Special Investigation Initiated - Letter Emailed referral to APS.
05/10/2021	Contact - Telephone call made Interview conducted with complainant by telephone.
05/10/2021	Contact - Telephone call made Interview conducted with residents' relative by telephone.
05/12/2021	Inspection Completed On-site
05/20/2021	Exit Conference Exit conference conducted with facility AR by telephone.

ALLEGATION:

Medications were not properly administered to Residents A and B.

INVESTIGATION:

On 3/19/21, licensing staff received a complaint intake. The complaint intake did not contain any allegations related to medication or medication administration.

On 5/10/21, a telephone interview was conducted with the complainant. The complainant stated that they did not have anything to add to the initial complaint intake.

On 5/10/21, a telephone interview was conducted with Relative AB. Relative AB stated that sometimes during medication administration facility staff would leave medications with Residents A and B, rather than observe the residents taking the medications. Relative AB stated that the residents did not know which medications belonged to which resident.

Residents A and B were admitted to the facility on 7/31/20 and discharged on 9/30/20.

Separate interviews were conducted on-site with med tech Shauntella Williams and med tech/caregiver Deandra Schultz. Ms. Williams and Ms. Schultz both stated that it was their practice when administering medications to watch residents take their medications.

During the on-site inspection a tour of the facility was conducted, and 10 resident rooms were inspected. No medications were observed sitting out in residents' rooms.

Separate interviews were conducted on-site with Residents C and D. Both Resident C and Resident D stated that facility staff occasionally leave their medications with them to take on their own.

Service plans for Residents A, B, C, and D were reviewed. It was noted that the service plans for Residents A, B, and C indicate that the residents require total assistance for medications, while Resident D requires only minimal assistance with medications according to their service plan.

Resident D's medication administration record was reviewed. It was noted that the facility manages and administers Resident D's medications.

According to Mr. Cortis, the medication administration process is the same for residents who require total assistance as it is for residents who require minimal assistance. Mr. Cortis stated that the difference between the minimal assistance and total assistance designations is the resident's overall mental acuity and understanding of their medication regimen.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(2) The giving, taking, or applying of prescription medications shall be supervised by the home in accordance with the resident's service plan.

ANALYSIS:	Based on the statements of Residents C and D, this allegation is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The facility did not meet Resident A's personal care needs.

INVESTIGATION:

On 3/19/21, licensing staff received a complaint intake that alleged in-part that facility staff "left [Resident A] in a wet diaper for four hours and allowed [Resident A] to wet the bed." It was also alleged that "[Resident A] would push the call button and the staff wouldn't assist in coming to the room."

Relative AB restated these allegations.

Resident A's service plan was reviewed. The service plan indicated that Resident A was independent with toileting but did use incontinence briefs/pull-ups.

Ms. Schultz stated that Resident A was independent with toileting but wore briefs/pull-ups as a precaution. Ms. Schultz stated that staff conduct two-hour checks/changes for residents who utilize protective underwear, and that these were done for Resident A. According to Ms. Schultz, Resident A was capable of using the pendant/call light system to contact staff for help with toileting/changing and did so on occasion. Ms. Schultz stated that she could not recall a time when Resident A intentionally wet the bed, or was left in a wet, soiled pull-up for an extended amount of time.

An interview was conducted on-site with facility administrator Matthew Cortis. The statement of Mr. Cortis was consistent with that of Ms. Schultz with regard to staff completing two-hour checks/changes for residents in protective underwear.

Resident A's *Monthly Task Logs* from August and September were reviewed. It was noted that the resident required minimal assistance with dressing, with instructions reading "…[Resident A] is able to select clean clothing each day, but will require standby assist while she is dressing and may require some hands on assistance with lower extremities…" It was noted that this task was frequently documented by staff as "TNC" (task not completed). Additionally, it was noted that Resident A required moderate assistance with bathing, which was to occur twice per week. Resident A had 16 scheduled showers between 8/8/20 and 9/30/20. Task log documentation indicates that facility staff assisted Resident A with bathing on four

occasions, that the task was not completed on 11 occasions, and that the resident was “OOF” (out of facility) on one occasion.

Pendant/call light data was requested for Resident A. However, the facility’s call light system is unable to retrieve data from that timeframe. Instead, pendant/call light data from April 2021 was reviewed for Residents E and F. According to Mr. Cortis, facility staff is trained to respond to call lights immediately, however, it may take a few minutes sometimes depending on staff’s availability. While Resident E’s call light response data was overall consistent with the stated expectation (within a few minutes) of the administrator, it was noted that Resident F’s call light response times were excessive on numerous occasions, including 12 instances where staff response time exceeded 30 minutes, twice exceeding one-hour.

APPLICABLE RULE	
R 325.1933	**Personal care of residents.**
	(1) A home shall provide a resident with necessary assistance with personal care such as, but not limited to, care of the skin, mouth and teeth, hands and feet, and the shampooing and grooming of the hair as specified in the resident's service plan.
ANALYSIS:	A review of residents’ records and call light response times reveal a significant delay and occasional omissions in the provision of these services to residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Residents A and B’s room was not clean.

INVESTIGATION:

On 3/19/21, licensing staff received a complaint intake that alleged in-part that “There was food left in the room about four days worth. The trash wasn't taken out of the room.”

Relative AB restated these allegations.

During the on-site inspection a tour of the facility was conducted, and 10 resident rooms were inspected. It was noted that the general facility and resident rooms were clean, organized, and in good repair. Residents G and H’s room was observed to have stained floors with some debris/trash on the floor. According to Mr. Cortis, the

stains and debris are due to the residents' wheelchairs and inability to pick items up off the floor. Mr. Cortis stated that facility staff/housekeeping attempt to clean/vacuum the residents' room daily, and that the facility is looking into replacing the flooring in that room.

APPLICABLE RULE	
R 325.1979	**General maintenance and storage.**
	(1) The building, equipment, and furniture shall be kept clean and in good repair.
ANALYSIS:	Based on observations and facility staff interviews, these allegations could not be substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 3/21/21, licensing staff received an incident report from the facility that read:

Explain What Happened…

At approximately 2:00 P.M. Arjan Zaka (LPN) traveled home for a family emergency as he lives close to the community. Upon his return back to the community at approximately 2:10 P.M. he observed [Resident I] walking near the subdivision near the First State Bank which is close to the community. Arjan (LPN) assisted the resident to his vehicle and escorted him back inside the community at around 2:13pm. [Resident I] was alert, with no signs of distress and no signs of injury or bruises noted.

Three care team associate witness statements were obtained on 3/21/2021 stating [Resident I] was last observed in the community at approximately 1:30 P.M.

Upon conclusion on the investigation the first Eastside door leading out to the vestibule was not armed correctly. The second door was armed correctly leading to the outside of the community. [Resident I] sustained no injuries and the family is satisfied by the community's subsequent actions taken.

Action Taken by Staff…

- Physical resident count was taken of all residents in community on 3/21/2021.
- All memory care community doors were inspected by the Director of Plant Operations on 3/21/2021 and are in proper working order/and alarmed. Both East exit detex magnet alarms are armed and in working order.
- Immediate elopement associate education provided on 3/21/2021. Inservice education will continue until all care team members have been educated.
- Resident care plan has been updated to reflect scheduled documented care team visits 3 times pers day on 1st, 2nd, and 3rd shifts to observe the resident's location.

Corrective Measures Taken to Remedy and/or Prevent Recurrence:

- Ring door sensors have been added to both East exit doors that alerts the Director of Virtue/Memory Care, Plant Operations Director, Director of Health and Wellness, and Executive Director. A ring door chime alarm was installed at the front of the Virtue/ Memory community care team desk to alert the team members if the Eastside doors ajar.

- Weekly documented door checks have been initiated in which the Plant Operations Director, and or designee be responsible for.

- A review was completed in Virtue/Memory Care to indicate residents that are at-risk for a potential elopement.

During the on-site inspection on 5/12/21, Mr. Cortis restated and confirmed the above information and actions.

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.**
R 325.1901	**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:	On 3/21/21, memory care resident, Resident I left the facility and was found by staff within 40 minutes less than one mile away. Based on this information it is determined that the facility did not assure an organized program of protection for this resident. However, the facility is not required to address this violation in the corrective action plan, as the incident report sufficiently addressed and described the immediate actions taken by staff as well as the corrective measures taken to remedy and prevent recurrence.
CONCLUSION:	**VIOLATION ESTABLISHED**

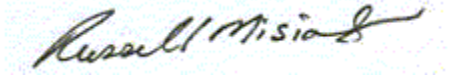
IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend no change in the status of the license.

5/17/21

Andrew Schefke — Date
Licensing Staff

Approved By:



5/18/21

Russell B. Misiak — Date
Area Manager