GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

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

May 24, 2021

RE: License #: AH820399661
Investigation #: 2021A1011027
Anthology of Northville

Dear Ms. Locricchio:

Attached is the Special Investigation Report for the above referenced facility. Due to the severity of the violations, disciplinary action against your license is recommended. You will be notified in writing of the department's action and your options for resolution of this matter.

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 (248) 975-5053.

Sincerely,

Andrea Krausmann, Licensing Staff
Bureau of Community and Health Systems
51111 Woodward Avenue - 4th Floor, Suite 4B
Pontiac, MI 48342
(586) 256-1632

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH820399661
Investigation #:	2021A1011027
Complaint Receipt Date:	04/07/2021
Investigation Initiation Date:	04/07/2021
Report Due Date:	06/07/2021
Licensee Name:	CA Senior Northville Operator, LLC
Licensee Address:	44600 Five Mile Rd Northville, MI 48168
Licensee Telephone #:	(312) 994-1880
Administrator:	Jeffrey Madak
Authorized Representative:	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:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Suspected mishandling and/or abuse of a resident.	No
Resident did not receive medications on 4/5 and 4/6/21.	No
Resident did not have a service plan upon admission.	Yes
Additional Findings	Yes

III. METHODOLOGY

04/07/2021	Special Investigation Intake 2021A1011027
04/07/2021	Special Investigation Initiated - On Site Interviews conducted and records reviewed.
04/09/2021	APS Referral Referral made to adult protective services (APS) via email.
04/13/2021	Contact - Telephone call made Interviewed receptionist Karen Romero.
04/13/2021	Contact - Telephone call made Interviewed Moesha Carlton.
04/13/2021	Contact - Telephone call made Interviewed Javionne Pierre.
04/13/2021	Contact - Document Received Documentation and information received from J. Madak via email as requested.
04/29/2021	Contact – Document Received Anthology facility policy on reporting/documenting suspected abuse from Michele Locricchio.
04/29/2021	Contact - Telephone call made Interviewed Michele Locricchio
05/05/2021	Exit Conference – Conducted with licensee authorized representative Michele Locricchio by telephone.

ALLEGATION:

Suspected mishandling and/or abuse of a resident.

INVESTIGATION:

On 4/7/21, I received a voice mail message from the facility's administrator Jeffrey Madak. Mr. Madak was calling to report suspected mishandling and/or abuse of a resident that he said was brought to his attention this morning. Mr. Madak also said we are doing an investigation. The staff member has been put on suspension and he will follow up with more information.

On 4/7/21, I went to the facility and interviewed Mr. Madak and director of health and wellness Laura Kujawski on-site. Mr. Madak said that he and Ms. Kujawski received an email earlier that morning from Resident A's daughter Relative A3, reporting mishandling and/or abuse of Resident A. Mr. Madak said he then suspended the staff reported to be responsible and Ms. Kujawski notified the local Northville Township police department. One police officer previously arrived, took pictures, but said he is not assigned the investigation. Another officer is to arrive soon.

Ms. Kujawski said she conducted a skin assessment of Resident A. She observed a skin tear on one arm and said the rest was "unremarkable". Ms. Kujawski said she asked Resident A about the skin tear and Resident A said she was in a fight and someone ripped her clothes off. Resident A declined to name who did it.

Mr. Madak provided a copy of Relative A3's email that he received that morning. The email indicated the incident occurred "yesterday evening" meaning Tuesday 4/6/21. Mr. Madak said given the staff identified as involved, it would have happened on Monday 4/5/21, not 4/6/21 as indicated. The email alleged that no staff would take Resident A back to her room after dinner. Dining room staff wheeled Resident A into the lobby to clean the dining room. She had been sitting there trying to get someone to help her back to her room for over an hour. The receptionist then returned her to her room but was not able to toilet her, because that is not her job. Staff Moesha then went to Resident A "somewhere around 7:30 according to [Resident A]" and told Resident A that she was going to undress her for bed after toileting her. Resident A did not want to be undressed at 7:30 because that is not her routine on any night. "Moesha apparently got angry and insisted and tried to forcibly take [Resident A's] clothes off her, resulting in [Resident A's] ribs being jabbed, her very fragile legs being twisted, and her arms yanked; one of her arms sustained a horrible bruise and a deep cut that seems to be the result of fingernails digging into her arm. Moesha then tried to put two briefs on [Resident A] at once, telling [Resident A] that she was doing it so no one would have to come to take [Resident A] to the bathroom during the night. Naturally, [Resident A] refused to go along with that."

On 4/7/21, I accompanied Northville Township Police Officer Dan MacArthur, as he interviewed Resident A in her room. Resident A's family member Relative A1 was

also present. Resident A explained that after dinner, the dining room closes at 7 pm. Resident A said staff "Geneva" pushed Resident A in her wheelchair into the lobby and went to look for staff to take her back to her room. Resident A said she sat for "15 minutes" in the lobby before she was pushed back to her room. Resident A said it was about 7 pm when staff person Moesha wanted to put her in her nightgown, but she did not want that. Resident A explained that her vision is limited but she believes the staff person's name was Moesha because she provided her name earlier in the evening and because Resident A knows her voice.

Resident A said she was sitting on the toilet when the Moesha "got into an argument with me" and she described how the staff removed her shoes, socks, and pants, as Resident A sat on the toilet and struggled to keep them on. Resident A said she did not want to be in her night gown that early in the evening because she would stay up awhile longer, and she would get cold. Resident A said the staff offered her a blanket, but she refused. The staff reportedly continued to remove Resident A's clothes and Resident A said she was "fighting" with the staff to keep her clothes on. Resident A explained how the staff was pulling her shirt off and said, "I was fighting with her. I got caught on something, jewelry or something" referring to an injury to her left arm that had been bandaged. Resident A also said Moesha tried to put two briefs on her but she refused, and it was not done.

Resident A said she remained in her wheelchair until "someone" helped her to bed. Resident A said the next day the caregiver went to change her bedding and she noticed blood on the sheets.

Resident A clarified a different staff put her in bed and she woke up at 3 am but she was unaware of blood on her sheets. When she got up in the morning to get dressed the blood was observed through her shirt sleeve and a medication passer "put something for wounds on it." Resident A said she hurt all over from having to fight with the staff. Resident A complained of pains in both arms, shoulders, wrists, her legs, her left knee bone and said that her right knee had been replaced but it also hurt from pulling against the staff. Resident A said her ribs on the right side hurt. Resident A said a caregiver said her right leg had been swollen but put Biofreeze on both and the caregiver said the swelling was going down. Resident A said she had a headache and her neck hurt from being "tossed around".

Resident A explained that she can call her family about her concerns by speaking aloud to her Alexa device, but said she did not call her family the night this happened.

Mr. Madak said the facility provides Resident A with a one-on-one caregiver Riley Walter approximately five days a week. Mr. Madak said Ms. Walter informed him at approximately 6 pm on 4/6/21 that she had "concerns about something" that Resident A was saying happened on 4/5/21. Mr. Madak said he did not know what the "concerns" were but told Ms. Walter to put it in writing before he was to leave that evening. Mr. Madak said she did not do so. Then, he received this email from

Resident A's family on 4/7/21. Mr. Madak said physician assistant Kristi Morris was presently in the facility and she has been informed. She has assessed Resident A.

On 4/7/21, I interviewed Resident A's primary health care provider, physician assistant Kristi Morris, at the facility. Ms. Morris said she has been treating Resident A since February 2021. Ms. Morris explained that she is responsible for providing medical services to Resident A under the supervision of Dr. Sarafa at Avalon Physician Services. Ms. Morris affirmed that communication from the home about Resident A goes to Ms. Morris. Ms. Morris said she does not believe Dr. Sarafa has seen Resident A.

Ms. Morris said she saw Resident A at 9 am this morning per usual rounds, and she was unaware of any of this because Ms. Kujawski was not yet in the facility. Ms. Morris said Resident A told Ms. Morris that she hurt all over. Ms. Morris said this is not uncommon for Resident A to say. Ms. Morris said she asked Resident A about the bandaid on her arm and Resident A said she was in a fight. Resident A also told Ms. Morris that the staff gave her Tylenol. Ms. Morris said her vital signs were normal. Again, she was complaining of pain all over but that is not uncommon. Ms. Morris said she did not look at the injury under the bandage, but she would do so. Ms. Morris said a little time later while she was still at the facility with another resident, Ms. Kujawski notified her of the family's report of Resident A's alleged incident.

Together, we returned to Resident A's room. Ms. Morris asked Resident A to see the injury and very carefully removed the bandage on her left arm near the elbow. It appeared to be a half circle bruised skin tear the approximate size the circumference of a quarter. Ms. Morris asked Resident A about the injury and Resident A said she was in a fight with staff. Resident A again said she hurt all over, and said her hands, wrists, legs, and ribs hurt because she was fighting staff and pulling away. Ms. Morris then checked these areas and said she observed no bruises anywhere.

Ms. Morris said Resident A is not on any blood thinner, but she does take acetaminophen daily. Ms. Morris said Resident A's elbow could have hit or bumped anything and caused that skin tear. Ms. Morris explained Resident A has said she is dizzy at times and will catch herself falling to the right or left while seated in the wheelchair. A bump on the wheelchair from this catching herself, can also cause such a skin tear. Ms. Morris said if Resident A had been grabbed, she would have expected to see bruising but it is already days later and there is no bruising. Ms. Morris said Resident A's complaints of pain all over is typical for her. Ms. Morris explained she did not see any bruising on her, and while examining her legs, Resident A's replies and movements revealed inconsistencies in describing and demonstrating pain. Ms. Morris denied observation of any evidence of mishandling or abuse.

On 4/7/21, I interviewed Resident A's one-on-one caregiver Riley Walter at the facility. Ms. Walter said that about 1 pm on 4/6/21 Resident A told her that on 4/5/21

at 7:30 pm a caregiver wanted to get her ready for bed. The caregiver was fighting her trying to get her clothes off and twisted her leg. A nail or bracelet scratched her arm. Resident A reportedly said she did not want to change her clothes because it was too early, and she would be cold. Ms. Walter said she noticed some blood on Resident A's shirt sleeve and some on her bed sheets, then said, "it was not readily noticeable". Ms. Walter said she never did wound care before, so she told med tech Tera Ross of the injury about 4 pm. Ms. Ross then assisted Ms. Walter with using wound care cleanser and applying a bandage.

Ms. Walter said when she told Ms. Ross at 4pm, Ms. Ross directed her to inform Mr. Madak. Ms. Walter said she then told Mr. Madak, "I think something happened with [Resident A] because she claimed someone beat her up on Monday and she has a skin cut or something on her arm. I told him about 4 pm yesterday and he told me to write something up before I leave and give it to him, but I forgot." Ms. Walter said she has not completed an incident report or anything in writing.

Ms. Walter said Resident A thinks the caregiver responsible for the alleged incident is a person whose name starts with "Moe".

Ms. Walter said Resident A "complains a lot when she is stood up. She says her legs hurt so bad, especially her right leg." Ms. Walter said this is common for her to complain of pain. Ms. Walter said she checked Resident A and she did not see any bruises on her rib cage or anywhere. Ms. Walter explained application of her usual Biofreeze to her legs. Ms. Walter said she noticed Resident A's left leg was "a little red" but then said it was "insignificant". Ms. Walter said she noticed a "dot" on the back of her neck then explained that it could be from the heat of a rice pack that she puts there.

On 4/13/21, I interviewed receptionist Karen Romero by telephone. Ms. Romero said she recalled the night that staff moved Resident A from the dining room to the lobby by the fireplace, so they could clean the floor. Ms. Romero said staff informed Resident A that someone would be by to take her to her room. Ms. Romero was conversing with another resident but could see and hear Resident A in the lobby. Ms. Romero said Resident A then started screaming and yelling that she was going to call her daughter and tell her that she was left there for an hour. Ms. Romero said she spoke with Resident A, informed her that it had only been five minutes and said she would take her upstairs, but she had to let out a person with a visiting dog. Ms. Romero said she turned around from the door and another staff was already taking Resident A up to her room. Given Resident A's statement of what she would tell her daughter was not true, Ms. Romero said she knew she should document that it was not more than five minutes that Resident A had waited in the lobby for staff to take her to her room. Ms. Romero said she documented it in the staff communication records.

On 4/13/21, I interviewed caregiver/med passer staff Moesha Carlton by telephone. Ms. Carlton explained that she escorted Resident A to the dining room that night.

Ms. Carlton said she was informed that Resident A knows how to feed herself, but staff need to tell Resident A what food is where on the plate and said that she provided that information. However, Resident A was upset that Ms. Carlton would not stay with her during dinner. Ms. Carlton explained she had other residents to tend to.

Ms. Carlton said she was then passing medications to residents at about 7 pm, when co-worker Javionne Pierre informed her that Resident A was screaming and hollering that I left her there in the lobby for an hour, when she had been there less than five minutes. Ms. Pierre then took Resident A to her room and assisted her to the toilet. Ms. Carlton said she then went to Resident A to get her ready for bed. Ms. Carlton said when she they exited the bathroom as Ms. Carlton pushed Resident A in her wheelchair, Resident A nicked her arm door latch plate. Ms. Carlton said Resident A was "hysterical" and she was mad, but Ms. Carlton told her that it was ok. Ms. Carlton said there was no blood, but she did tell the team lead A'Shari Anderson that it happened. Ms. Carlton said she should have written an incident report, but she was busy that night when another med tech left her shift early and Ms. Carlton had to pass her medications too. Ms. Carlton said she forgot to complete an incident report and has not done so.

Ms. Carlton said she then dressed Resident A into her night clothes in her room because Resident A does not like to be changed in the bathroom. When asked if Resident A resisted or refused to be changed, Ms. Carlton said "Only in she likes to put her own shirt on and said, 'No, just show me the hole' where her head goes through". Ms. Carlton said Resident A's pants were already down from being on the toilet when placed there by Ms. Pierre. Ms. Carlton said Resident A did not refuse or say no to putting on her bed clothes. Ms. Carlton said we can't force them to get ready for bed and if she had refused, Ms. Carlton said she would have come back later.

In regard to the application of two briefs, Ms. Carlton said Resident A wears pull-ups and we only put on one. We never offer to put on two. Ms. Carlton said Resident A usually puts a pad on the inside of her briefs, but she could not recall if she did that evening.

On 4/13/21, I interviewed staff Javionne Pierre by telephone. Ms. Pierre's recall of the 4/5/21 events were that after dinner Resident A wanted to go to her room and Ms. Pierre offered to take her. Ms. Pierre said she assisted Resident A to the toilet. Afterward, Ms. Carlton then assisted her into clothes, as she was assigned to care for Resident A. Resident A was then seated in a chair by her television because she was not ready to go to bed. Ms. Pierre said she went back to Resident A's room later to help Resident A into bed. Ms. Pierre said she noticed the cut on her arm, but she thought it was an old cut. Resident A did not say anything to Ms. Pierre about Ms. Carlton putting her in her pajamas.

Ms. Pierre said she returned to work the day shift on 4/6/21 and she got Resident A up and out of bed. Ms. Pierre said she noticed some blood on Resident A's sheets. Resident A then told her that the person that put her into bed last night beat her. Ms. Pierre said Resident A reported her leg got twisted and something about her ribs, but Ms. Pierre did not see any bruises anywhere on her. Ms. Pierre told Resident A, "I was the one that put you in bed last night" and Resident A asked for her name. Ms. Pierre said she immediately went downstairs and told Jeff Madak and Laura Kujawski or Jasmine Parker, she was not certain if it was Ms. Kujawski or Ms. Parker, of what Resident A was saying. Ms. Pierre assured them that she did not put her hands on Resident A in that manner. Ms. Pierre said Mr. Madak told her to write a statement about it, but she forgot to do so. Ms. Pierre said she has not yet completed a statement or incident report.

Ms. Pierre said later that day a housekeeper asked her what happened last night. Ms. Pierre then told Resident A's caregiver Riley Walter that Resident A is trying to blame her for something. Ms. Walter then asked Resident A what happened and reportedly, Resident A told her "Moe" did it.

Ms. Pierre said of Ms. Carlton that she treats residents "very well. If she treated them bad, I would tell". Ms. Pierre said the residents like Ms. Carlton.

Resident A's service plan dated 3/8/21 reads, "Due to my limitations, I at times, can become verbally agitated and annoyed with care staff. To assist with this, my family will visit throughout the day and help the care staff learn how best to care for my needs and participate in my specific routine. . . I, at times, do not like to do things that will help me throughout the day. I may be resistant to care. This will improve after I develop a trusting relationship with my caregivers. I do better with a automatic routine throughout the day and evening . . . I will need assistance using one person to complete me (sic) grooming/hygiene needs . . . I will require assistance with dressing/undressing . . . I can feed myself however I need assistance with placement of where my food is located and at times helping me get the food on the fork." There is no information in her service plan that indicates Resident A wants to remain in her daytime clothes until she goes to bed.

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. . . Patients or residents shall be treated in accordance with the policy.

MCL 333.20201	**(2) (l) A patient or resident is entitled to be free from mental and physical abuse and from physical and chemical restraints, except those restraints authorized in writing by the attending physician or a physician's assistant to whom the physician has delegated the performance of medical care services for a specified and limited time or as are necessitated by an emergency to protect the patient or resident from injury to self or others, in which case the restraint may only be applied by a qualified professional who shall set forth in writing the circumstances requiring the use of restraints and who shall promptly report the action to the attending physician or physician's assistant. In case of a chemical restraint, a physician shall be consulted within 24 hours after the commencement of the chemical restraint.**
ANALYSIS:	Resident A's physician assistant Ms. Morris assessed Resident A and denied observation of any evidence of mishandling or abuse. Ms. Carlton's account of the skin tear occurring while wheeling her out of the bathroom and her arm catching on the door latch plate is a plausible explanation for the injury. Ms. Carlton denied offering to apply two briefs and denied that Resident A was resistant to changing her clothes, other than wanting to put her own shirt on a certain way. Resident A had the ability to call her family with Alexa communication device during or immediately after the alleged altercation, but she did not do so. Her accusations first of the person who put her to bed then changing it to Ms. Carlton being responsible for fighting with her was inconsistent. The evidence does not support inappropriate mishandling or abuse of the resident.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident did not receive medications on 4/5 and 4/6/21.

INVESTIGATION:

Additional information in the 4/7/21 email from Relative A3 to Mr. Madak and Ms. Kujawski alleged Resident A had not received her medications for the "last two days. She especially needed the Tylenol today because of the pain she was experiencing from her injuries."

Mr. Madak provided a copy of Resident A's medication administration record for April 2021. Staff documentation on this record confirmed Resident A's medications were administered including the Acetaminophen (Tylenol).

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(1) Medication shall be given, taken, or applied pursuant to labeling instructions or orders by the prescribing licensed health care professional.
ANALYSIS:	Staff documentation on the April 2021 MAR confirmed medication administered to Resident A.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident did not have a service plan upon admission.

INVESTIGATION:

During Officer MacArthur's 4/7/21 interview with Resident A, Relative A1 alleged that Resident A did not have a service plan upon admission into the facility. Relative A1 said an assessment was completed prior to admission but the service plan was not completed.

According to the Resident Face Sheet within Resident A's record, she moved into the facility on 2/18/21. Upon request of her initial service plan, I received Resident A's service plan dated 2/24/2021, that indicates it was completed by Laura Kujawski. I confirmed this was her first service plan. The service plan contained no evidence that it was prepared in cooperation with the resident and/or her authorized representative.

APPLICABLE RULE	
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.
R 325.1901	**Definitions.**
	(21) "Service plan" means a written statement prepared by the home in cooperation with a resident and/or the resident's authorized representative or agency responsible for a resident's placement, if any, and that

	identifies the specific care and maintenance, services, and resident activities appropriate for each individual resident's physical, social, and behavioral needs and well-being and the methods of providing the care and services while taking into account the preferences and competency of the resident.
ANALYSIS:	The facility provided no evidence that a service plan was developed upon Resident A's 2/18/21 admission in cooperation with the resident or her authorized representative. The service plan was dated 2/24/21.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Ms. Carlton, Ms. Pierre, and Ms. Walter were aware of the skin tear on Resident A's arm. Ms. Pierre and Ms. Walter were also aware of the allegations Resident A made about being in a fight with staff. None of them documented the reportable incident.

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, accidents, elopement.**
	(1) The home shall complete a report of all reportable incidents, accidents, and elopements. The incident/accident report shall contain all of the following information: **(a) The name of the person or persons involved in the incident/accident.** **(b) The date, hour, location, and a narrative description of the facts about the incident/accident which indicates its cause, if known.** **(c) The effect of the incident/accident on the person who was involved, the extent of the injuries, if known, and if medical treatment was sought from a qualified health care professional.** **(d) Written documentation of the individuals notified of the incident/accident, along with the time and date.** **(e) The corrective measures taken to prevent future incidents/accidents from occurring.**
For Reference: R 325.1901	**Definitions.**
	(17) "Reportable incident/accident" means an intentional or unintentional event in which a resident suffers harm or is at risk

	of more than minimal harm, such as, but not limited to, abuse, neglect, exploitation, or unnatural death.
ANALYSIS:	Three staff were aware that Resident A sustained a skin tear, and two of staff were aware that she made allegations of being abused by staff, however, no incident report was documented.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

The evening of 4/5/21, Ms. Carlton was aware that Resident A had a skin tear on her arm as a result of catching it on the door latch plate. Ms. Carlton said she notified lead A'Shari Anderson. The morning of 4/6/21 Ms. Pierre saw the blood on the sheets. Ms. Pierre notified Mr. Madak and Ms. Kujawski or Ms. Parker of the allegations Resident A made. The afternoon of 4/6/21 Ms. Walter notified Mr. Madak of Resident A's allegations and injury. The staff denied having notified Resident A's authorized representative of the injury.

Resident A's primary health care provider physician assistant Kristi Morris said she was unaware of Resident A's injury until she saw the bandage upon her assessment on 4/7/21. Ms. Morris said she was unaware of Resident A's allegations of abuse until after seeing Resident A, when Ms. Kujawski arrived at work and then told her of the family email.

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, accidents, elopement.**
	(3) The home shall report an incident/accident to the department within 48 hours of the occurrence. The incident or accident shall be immediately reported verbally or in writing to the resident's authorized representative, if any, and the resident's physician.
ANALYSIS:	The home did not immediately report the 4/5/21 skin tear nor the 4/6/21 allegations of abuse to Resident A's authorized representative and physician.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

Ms. Carlton said she began working for the home in September 2020 and reportedly completed Relias orientation training including resident rights and responsibilities,

resident service plans and personal care. Ms. Carlton said she did three days of training with experienced staff. The first day was observation and the next two days were hands-on. Ms. Carlton affirmed that she works independently with residents in providing personal care and administering medications.

Contrary to this information, when asked for documentation of training that Ms. Carlton completed from the employee record, Mr. Madak said Ms. Carlton is one of the staff that had not completed any training. The facility was previously cited on the lack of staff training in the recent 3/25/21 renewal Licensing Study Report. Mr. Madak said he is currently working on the corrective action plan for the renewal Licensing Study Report to assure all staff complete training.

Review of the licensing file revealed Mr. Madak was appointed administrator on 10/19/20.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(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: **(a) Reporting requirements and documentation.** **(b) First aid and/or medication, if any.** **(c) Personal care.** **(d) Resident rights and responsibilities.** **(e) Safety and fire prevention.** **(f) Containment of infectious disease and standard precautions.** **(g) Medication administration, if applicable.**
ANALYSIS:	Jeffrey Madak was appointed administrator on 10/19/20. The facility was cited in a recent renewal licensing study report dated 3/25/21, as employees not always completing the staff training program before working independently with residents. As of 4/7/21, Mr. Madak had still not implemented a staff training program for employees such as Ms. Carlton, who had worked in the home since September 2020.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED [Ref: Licensing Study Report dated 3/25/21]**

INVESTIGATION:

The facility was previously cited for not evaluating employee competency in the recent 3/25/21 renewal Licensing Study Report. On 4/7/21 Mr. Madak said he is currently working on the corrective action plan for the renewal Licensing Study Report regarding the development of methods for employees to demonstrate competency in their training. Mr. Madak said Ms. Carlton is one of the staff whose competency has not yet been evaluated.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(7) The home's administrator or its designees are responsible for evaluating employee competencies.
ANALYSIS:	As previously cited in a licensing study report dated 3/25/21, Mr. Madak had not yet developed methods for evaluating employee competencies on various training. The administrator or designee has not yet evaluated competency of employees such as Ms. Carlton, who works independently with residents.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED [Ref: Licensing Study Report dated 3/25/21]**

INVESTIGATION:

Javionne Pierre said she reported Resident A's allegations of abuse to administrator Jeffrey Madak the morning of 4/6/21. Riley Walter said she reported Resident A's allegations of abuse and injury to Mr. Madak at 4 pm on 4/6/21. Other than telling both staff to document it in writing, Mr. Madak took no other immediate action to address the allegations. In addition, when both staff failed to submit anything in writing, Mr. Madak took no action. Mr. Madak did not respond to Resident A's allegations until he received an email from Resident A's family the following day 4/7/21, and then he suspended Ms. Carlton and had Ms. Kujawski notify police.

On 4/29/21, I received Anthology's abuse policy from licensee authorized representative Michele Locricchio via email. According to the policy,

> *"All employees of the community are MANDATED REPORTERS and should report any known or suspected resident abuse, neglect or exploitation, immediately, without fear of reprisal, retaliation, disciplinary action, or termination by the community for that reason alone. Team members will be encouraged to report any signs or symptoms of any resident's aggressive behavior, both verbally and physically. Behaviors will be communicated to the physician. Types of Abuse Definitions of Abuse*

Abandonment - The leaving of a resident without the means or ability to obtain necessary food, clothing, shelter, or healthcare, either by action or inaction of a person or entity.

Abuse - The willful action or inaction that inflicts injury, unreasonable confinement, intimidation or punishment with resulting physical harm or pain or mental anguish…

REPORTING ABUSE Immediate action is required when an allegation of abuse occurs:

- *Remove resident from immediate danger*
- *Obtain medical care if necessary*
- *Follow appropriate steps, including completion of an incident report for each resident involved in any alleged or suspected occurrence*
- *Any alleged or suspected abuse, neglect or exploitation should be reported immediately to the Regional Director of Operations(RDO) and the Regional Director of Clinical Services (RDCS) to the required state agencies, regardless of the length of time since the alleged occurrence took place*
- *Reports should be made immediately to the Executive Director, Director of Health and Wellness or other appropriate supervisory personnel*
- *Executive Director or designee including the LN investigates all reports of alleged/suspected abuse or neglect*
- *Physical assault and/or sexual assault are considered crimes and must be reported to the local law enforcement agency along with notification to the state agency responsible for investigation when required by state regulations Follow law enforcement guidelines for evidence collection and preservation*

. . . INVESTIGATION

The investigation into allegations of abuse, neglect or exploitation will be conducted in privacy and documented by the Executive Director or designee using the Incident Report Form; which is housed in our electronic system, YARDI, the E.D. may delegate all or part of this investigation but he/she remains solely accountable for this process. The Health and Wellness department leaders may conduct the investigation as the designee.

- *Once an allegation of suspected abuse, neglect or exploitation has been reported, an incident report is completed*
- *The E.D. or designee immediately begins an investigation to establish the chain of events and circumstances leading to the allegation and to determine the validity of the allegation*

- *If gathering written statements from involved parties is warranted, consult with the Regional Director of Operations and the Regional Director of Clinical Services.*
- *Resident shall be evaluated by a healthcare provider*
- *All appropriate agencies and authorities notified*
- *The E.D. or designee notifies the Regional Director of Operations and Regional Director of Clinical Services of the findings from the investigation*

. . . ”

This investigation also revealed repeat rule violations of R325.1931(6)(a-g) and R325.1931(7). The facility had been previously cited on both rules in the renewal Licensing Study Report dated 3/25/21. During the 3/16/21 on-site licensing inspection, Mr. Madak confirmed there were employees that had not completed training based on the facility's program statement, the residents' service plans, reporting and documenting, personal care, and resident rights/responsibilities. Also, Mr. Madak said the facility had not developed methods for evaluating employee competencies on various training. As of this 4/7/21 on-site investigation [SIR2021A1011027], Mr. Madak still had not implemented a staff training program for those employees and had not yet developed methods for evaluating employee competencies.

In addition, special investigation report (SIR) #2021A1011023 revealed repeat violation of R325.1931(2). The facility had been previously cited in SIR2020A0585061 dated 11/20/20 when a resident's service plan lacked specific methods to ensure a safe transfer. The resident followed staff's verbal instruction and transferred himself to his motorized wheelchair without the staff member's assistance as required. During the process, a cap came off the wheelchair control exposing a metal piece. The resident injured his testicles on the metal during the transfer causing a cut to his scrotum and bleeding. The 11/20/20 Corrective Action Plan (CAP) [signed by the licensee authorized representative Michele Locricchio] indicated all resident service plans would be updated to reflect specific care added by 12/31/20. The Statement of Correction (SOC) dated 3/3/21 [signed by the licensee authorized representative Michele Locricchio] indicated all service plans were updated to reflect resident personal care needs by 12/31/20.

However, this R325.1931(2) was cited again in SIR2021A1026012 dated 3/1/21, when it was determined staff did not check on a resident every two hours, put the resident to bed fully dressed, and transferred the resident in an unsafe manner. The 3/15/21 CAP received on 3/31/21 indicated each resident service plan was reviewed and updated to reflect current individual needs by 3/31/21. [No SOC]

R325.1931(2) was cited a third time in SIR2021A1011023 when Resident A, who relies on staff to assist her with transfer, toileting and other personal needs, summoned staff assistance and documentation revealed staff's repeated delay in responses with examples ranging from 23 minutes to three hours.

SIR2021A1011023 also revealed repeat violation of R325.1931(5). The facility had been previously cited excessively long response times in SIR2020A0585061 dated 11/20/20 with examples ranging from 24 minutes to one hour. The 11/20/20 CAP read an Inservice would be conducted with an expectation of five-minute response time or less. In addition, the call light report would be reviewed weekly and any times in excess of 5 minutes would be reviewed at "stand-up" meetings. Also, staffing was reviewed to ensure adequate and required community staffing. All was

to be completed by 11/30/20. The SOC dated 3/3/21 indicated all measures were put in place by 11/30/20 in addition to positions for job openings posted.

However, this R325.1931(5) was cited again in SIR2021A1011023 when staff schedules were not filled as expected, excessively long response times remained on all three shifts for residents in all areas of the home, and response times ranged from 21 minutes to four hours and 46 seconds. The facility did not demonstrate compliance with their own standards nor with this rule.

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: **(d) Appoint a competent administrator who is responsible for operating the home in accordance with the established policies of the home.**
ANALYSIS:	On 4/6/21 Ms. Pierre and Ms. Walter informed Mr. Madak of Resident A's allegations of abuse. Mr. Madak did not follow the facility's policy for suspected abuse. Mr. Madak requested the staff involved to provide him a written statement but took no action to ensure the immediate protection needs of that resident. In addition, he lacked the judgement to ensure the staff provided the statements he requested. Mr. Madak took no action until he received an email from Relative A3 on 4/7/21. Mr. Madak's failure to take immediate action when he was aware of Resident A's allegation of abuse, and Mr. Madak's repeated failure to implement corrective action plans reveals a lack of administrative competency required by this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

Review of the facility licensing file revealed licensee authorized representative Michele Locricchio signed the facility's corrective action plans (CAP) dated 3/15/21 and 11/20/20 and statement of correction (SOC) dated 3/3/21 in attestation that the CAP had been instituted and compliance maintained.

On 4/29/21, I interviewed Ms. Locricchio by telephone. In regard to determining compliance with licensing rules and implementation of the facility's corrective action plans, Ms. Locricchio said she relies on the facility's administrator Jeffrey Madak to

ensure implementation and run the day-to-day operation of the home. Ms. Locricchio said she takes Mr. Madak at his word and trusts that Mr. Madak will notify her with anything additional needed.

Specifically, in regard to R325.1931(2) and the CAP dated 11/20/20 (received 12/9/20) as well as the SPC dated 3/3/21to SIR2020A0585061, and CAP dated 3/15/21 to SIR2021A1026012, Ms. Locricchio said she received verbal confirmation that Ms. Kujawawski was updating service plans with a change of condition.

In regard to R325.1931(5) sufficient staff on duty to respond to call lights in a timely manner, CAP dated 11/20/20 (received 12/9/20) as well as the SPC dated 3/3/21 to SIR2020A0585061, Ms. Locricchio said she is aware of an audit in place regarding call light response time. Ms. Locricchio said she believes that staff may just be forgetting to clear the call light when responding to the resident, as is happening in other facilities that she oversees. Ms. Locricchio also said she believes a staffing agency has been contracted within the past few weeks. Again, Ms. Locricchio said she relies on Mr. Madak to implement the corrective actions plans as written.

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: 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:	Licensee authorized representative Michele Locricchio attested by signing CAP's and SOC that corrective action plans would be implemented, and compliance had been achieved. Ms. Locricchio stated she relied on the facility's administrator Jeffrey Madak statement that compliance was met. Repeat violations occurred revealing the operator of the home has not maintained an organized program of protection for its residents. The lack of oversite and accountability of the administrator by the licensee authorized representative does not reasonably assure compliance with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 5/5/21, I reviewed the findings of this report with licensee authorized representative Michele Locricchio by telephone. Ms. Locricchio said she has begun addressing the issues and spending time on-site with the administrator. She also notified corporate staff and has solicited the assistance of corporate nurses.

IV. RECOMMENDATION

A corrective notice order is recommended, consistent with the recommendation of special investigation report #2021A1011023.

5/5/21

Andrea Krausmann Date
Licensing Staff

Approved By:

5/5/21

Russell B. Misiak Date
Area Manager