GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 24, 2021

Matthew Cortis
Anthology of Rochester Hills
1775 S. Rochester Rd
Rochester Hills, MI 48307

RE: License #: AH630398529
Investigation #: 2021A1019055
Anthology of Rochester Hills

Dear Mr. Cortis:

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 #:	AH630398529
Investigation #:	2021A1019055
Complaint Receipt Date:	09/07/2021
Investigation Initiation Date:	09/07/2021
Report Due Date:	10/07/2021
Licensee Name:	CA Senior Rochester Hills Operator, LLC
Licensee Address:	1775 S. Rochester Rd Rochester Hills, MI 48307
Administrator and Authorized Representative:	Matthew Cortis
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:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A didn't received medications as prescribed.	Yes
Additional Findings	No

III. METHODOLOGY

09/07/2021	Special Investigation Intake 2021A1019055
09/07/2021	Special Investigation Initiated - Letter Emailed administrator for additional information after receipt of incident report on 9/3/21.
09/07/2021	APS Referral Notified APS of the allegations via email referral template.
09/21/2021	Inspection Completed On-site
09/21/2021	Inspection Completed-BCAL Sub. Compliance
09/24/2021	Exit Conference

ALLEGATION:

Resident A didn't received medications as prescribed.

INVESTIGATION:

On 9/3/21, director of health and wellness Edwin Feys submitted an incident report that read:

> The patient consumed all of his seizure medications and it was ordered from the pharmacy in a timely manner but was not delivered. When the pharmacy was queried they said he wasn't due for a refill until 9/4/21. The resident went without his medication for four days. The resident was sent to the hospital for a possible seizure on 9/02/2021 and returned before midnight. The pharmacy sent a three day emergency supply on 9/02/21 and it was administered.

On 9/21/21, I conducted an onsite inspection. I interviewed Mr. Feys at the facility. Mr. Feys stated that Resident A receives medication for seizures and that the medication was reordered through the facility's contracted pharmacy, Omnicare on 8/22/21. Mr. Feys stated that the last dose given to Resident A before running out was on 8/28/21. Mr. Feys stated that on 8/31/21, a facility med tech contacted the pharmacy because the medication still had not been delivered and the pharmacy informed staff that it was too soon to refill and that insurance wouldn't authorize it.

On 9/2/21, Resident A's wife reported to staff that Resident A had a seizure. Mr. Feys stated that Resident A was observed to be sleeping in bed with no evidence of a seizure, but they had him evaluated at the hospital as a precaution. Mr. Feys stated that he and administrator/authorized representative Matt Cortis became aware of the medication issue on 9/2/21 and were able to obtain a three day emergency supply of the medication that day and it was available to administer to the resident upon his return from the hospital. Mr. Feys stated that on 9/4/21, Resident A's regular 30-day supply of the medication was delivered to the facility and there have not been any issues since.

Resident A's medication administration record was reviewed (MAR). The MAR indicates that Resident A receives the medication Levetiracetam, two tablets twice daily. The MAR identifies that Resident A only received on dose of the medication on 8/28/21 at 9:24am. Mr. Feys stated that staff were out of the medication completely until 9/2/21. The next administration that staff documented after receiving the medication on 9/2/21 occurred on 9/3/21 at 9:27am. In total, Resident A missed eleven doses of medication from 8/28-9/2/21. Additionally, numerous instances of medications being administered late (several hours after the scheduled administration time) were observed. Administrator and authorized representative Matt Cortis stated that the facility has a two hour window to pass medications from the scheduled administration time.

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:	Resident A missed eleven doses of medication over a six day period. Medications were also observed to be given late on multiple occasions throughout the timeframe reviewed.
CONCLUSION:	**VIOLATION ESTABLISHED**

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.**
ANALYSIS:	While medications were reordered prior to running out, the facility lacked timely follow through and communication in order to obtain the medication before Resident A missed several doses.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Mr. Feys stated that the facility did not have the medication onsite to administer to Resident A from 8/29/21-9/2/21. Review of Resident A's MAR revealed that staff documented the medication was administered to Resident A for one dose on 8/29/21, two doses on 8/30/21 and one dose on 8/31/21. Mr. Feys determined that the documented doses on 8/29-8/31 were the result of documentation errors.

APPLICABLE RULE	
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: **(b) Complete an individual medication log that contains all of the following information:** **(i) The medication.** **(ii) The dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) The initials of the person who administered the medication, which shall be entered at the time the medication is given.**

ANALYSIS:	Staff incorrectly documented medication administrations to Resident A that never occurred.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED [For reference, see licensing study report (LSR) dated 111/23/20, CAP dated 12/4/20]**

On 9/24/21, I shared the findings of this report with authorized representative Matt Cortis. Mr. Cortis verbalized understanding of the citations and did not have any additional questions.

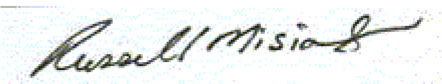
IV. RECOMMENDATION

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

9/24/21

Elizabeth Gregory-Weil Date
Licensing Staff

Approved By:



9/24/21

Russell B. Misiak Date
Area Manager