STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

October 20, 2021

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

RE: License #: AH820399661
Investigation #: 2022A1019001
Anthology of Northville

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. 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 #:	AH820399661
Investigation #:	2022A1019001
Complaint Receipt Date:	10/04/2021
Investigation Initiation Date:	10/05/2021
Report Due Date:	12/03/2021
Licensee Name:	CA Senior Northville Operator, LLC
Licensee Address:	44600 Five Mile Rd Northville, MI 48168
Licensee Telephone #:	(312) 994-1880
Administrator and 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:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Staff did not provide proper assistance to Resident A after he fell out of bed.	No
Additional Findings	Yes

III. METHODOLOGY

10/04/2021	Special Investigation Intake 2022A1019001
10/05/2021	Comment Complaint was forwarded to LARA from APS. APS denied the referral and did not assign it for investigation.
10/05/2021	Special Investigation Initiated - Letter Emailed admin/AR for census and staff schedules.
10/12/2021	Inspection Completed On-site
10/12/2021	Inspection Completed BCAL Sub. Compliance
10/15/2021	Exit Conference

ALLEGATION:

Staff did not provide proper assistance to Resident A after he fell out of bed.

INVESTIGATION:

On 10/4/21, the department received a complaint alleging that staff did not provide assistance when staff fell out of bed and requested to be taken to the bathroom on 9/27/21. The complaint read that she asked an unknown staff member to help her and the staff gave her an excuse to not help. The complaint read that the staff then informed the nurse (name unknown) and the nurse told her to get her if no one else would help. The complaint read that staff member “Shantae” (last name unknown) yelled at her for asking for help and did not come to her aid. The complaint read that supervisor “Sharita Miller” said she would have left Resident A on the floor.

On 10/12/21, I conducted an onsite inspection. I interviewed administrator and authorized representative Michele Locricchio at the facility. Ms. Locricchio stated that Resident A uses a wheelchair for ambulation and requires assistance of one person for transfers and toileting. Ms. Locricchio stated that Resident A has had a recent decline which has warranted hospice services. Ms. Locricchio stated that Resident A resides in the same apartment as his wife, who suffers from some memory and cognitive impairments. Ms. Locricchio stated that part of the reason hospice services were initiated was due to his increased falling. Ms. Locricchio stated that Resident A was frequently falling out of bed. Ms. Locricchio stated that Resident A now has a hospital bed which is in the lowest position, a fall mat and a concave mattress to assist in fall prevention. Ms. Locricchio stated that Resident A does have a call pendant to use when assistance is needed, and that he has the capability to utilize it. Ms. Locricchio stated that staff did not notify her of any issues from that date.

Facility schedules were reviewed and based on the names of staff referenced, it was determined that the alleged incident occurred during third shift on 9/27/21 going into the morning of 9/28/21.

Shift supervisor Charita Miller was not present during my onsite inspection, however she submitted a signed statements that read:

> A couple of weeks ago Wendy called me saying [Resident A] was on the floor, I went up to the room. Shante and Wendy had already gotten [Resident A] up and into his wheelchair. I checked [Resident A] for any bruising or skin tears none was [sic] present. I asked if he was in any pain he said no. He wasn't on the floor. Wendy and Shante found him in sitting position on his floor mat. I then [sic] explained to Wendy that the floor mats was placed there for his safety and rolling on the mat was not a fall.

Care staff Shante Gardner was not present during my onsite inspection, however she submitted a signed statement that read:

> Wendy asked me to help get [Resident A] up because he was on his bounce mat. I went in to help get [Resident A] to [sic] into his wheelchair, he was sitting up on the bounce mat next to his bed. Wendy and I got [Resident A] in his wheelchair, he said he needed to go to the bathroom and Wendy said she could take him, she did not need my help. I left to go take care of other things.

Upon receipt of Ms. Miller and Ms. Gardner's statements, Ms. Locricchio clarified that "Wendy" is a caregiver that was sent to the facility through Shift Med Staffing and that the last date she was at the facility was 9/27/21. Ms. Locricchio stated in speaking with staff who worked alongside Wendy, it was reported that she was very difficult to work with and didn't get along with other staff. Ms. Locricchio stated that Wendy has been placed on the "do not return list" with the staffing agency. Ms.

Locricchio stated that while the incident did not rise to the expectation of a state reportable incident, she would have expected Wendy to document the event in a progress note and internal incident report form, which she failed to do.

Resident A’s service plan was reviewed. The plan identifies Resident A as wheelchair bound, requiring assistance with transferring and toileting. The plan dated 9/15/21 reads “[Resident A] requires the assistance of one team member to transfer” and “[Resident A] requires physical assistance of one staff member to assist with transfer to the toilet, and requires team member to assist with peri care, to help prevent skin breakdown and odor.”

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.
ANALYSIS:	Attestations from staff present demonstrate care consistent with Resident A’s service plan.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Review of staff progress notes reveal that Resident A began receiving hospice services on 9/17/21. Additionally, Ms. Locricchio identified Resident A as a fall risk, and uses a hospital bed, concave mattress and fall mat as part of his fall prevention protocol. Resident A’s service plan lacked the abovementioned information.

APPLICABLE RULE	
R 325.1922 (5)	**Admission and retention of residents.**
	(5) A home shall update each resident's service plan at least annually or if there is a significant change in the resident's care needs. Changes shall be communicated to the resident and his or her authorized representative, if any.

ANALYSIS:	Resident A’s care needs changed with the initiation of hospice services and implementation of fall prevention devices.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED [For reference, see licensing study report (LSR) dated 3/25/21, CAP dated 8/16/21]**

On 10/15/21, I shared the findings of this report with authorized representative Michele Locricchio. Ms. Locricchio verbalized understanding of the citation and did not have any questions.

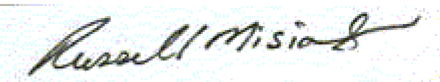
IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no changes to the status of the license at this time.

10/15/21

Elizabeth Gregory-Weil   Date
Licensing Staff

Approved By:



10/20/21

Russell B. Misiak   Date
Area Manager