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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 16, 2022

Michele Locricchio
Anthology of Farmington Hills
30637 W 14 Mile Rd
Farmington Hills, MI 48334

RE: License #:	AH630402476
Investigation #:	2022A1021066
	Anthology of Farmington 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 authorized representative 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 (517) 284-9730.

Sincerely,

Kimberly Horst, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630402476
Investigation #:	2022A1021066
Complaint Receipt Date:	09/22/2022
Investigation Initiation Date:	09/28/2022
Report Due Date:	11/22/2022
Licensee Name:	CA Senior Farmington Hills Operator, LLC
Licensee Address:	Suite 2100 130 E Randolph St Chicago, IL 60601
Licensee Telephone #:	(312) 994-1880
Administrator:	Kelleigh Peddy
Authorized Representative:	Michele Locricchio
Name of Facility:	Anthology of Farmington Hills
Facility Address:	30637 W 14 Mile Rd Farmington Hills, MI 48334
Facility Telephone #:	(248) 983-4780
Original Issuance Date:	03/30/2022
License Status:	TEMPORARY
Effective Date:	03/30/2022
Expiration Date:	09/29/2022
Capacity:	120
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Staff failed to respond and treat respiratory distress of Resident A.	Yes
Additional Findings	Yes

III. METHODOLOGY

09/22/2022	Special Investigation Intake 2022A1021066
09/28/2022	Special Investigation Initiated - Telephone interviewed facility by telephone
09/30/2022	Contact - Document Received received chart notes for Resident A
10/04/2022	Contact - Telephone call made interviewed SP1
10/12/2022	Contact - Telephone call made interviewed SP2
10/12/2022	Contact - Telephone call made interviewed SP4
10/22/2022	Contact - Telephone call made interviewed SP3
12/16/2022	Exit Conference Exit Conference with authorized representative Michele Locricchio

ALLEGATION:

Staff failed to respond and treat respiratory distress of Resident A.

INVESTIGATION:

On 9/22/22, the licensing department received a complaint with allegations the facility failed to respond and treat respiratory distress of Resident A. The complainant alleged staff members reported Resident A had abnormal and labored breathing for two days and no action was taken by the facility. The complainant

alleged caregivers expressed concern of the health status of Resident A, but no additional support was provided. The complainant alleged Resident A's family was not informed of the change in health status until he was transferred to the hospital.

On 9/28/22, I interviewed administrator Kelleigh Peddy by telephone. Ms. Peddy reported Resident A was in the memory care unit and was on continuous oxygen. Ms. Peddy reported Resident A was not active with home care nor hospice. Ms. Peddy reported Resident A was lethargic at times. Ms. Peddy reported on 8/21/22, Resident A was at baseline in the morning but had a change of status later in the day. Ms. Peddy reported Resident A took his morning medications and was able to make his needs known. Ms. Peddy reported during the lunch hour, Resident A was non-responsive, not opening eyes, blood pressure was elevated, and oxygen was low. Ms. Peddy reported the facility contacted family and it was decided to send the resident out to the hospital. Ms. Peddy reported Resident A passed away at the hospital on 8/21/22. Ms. Peddy reported no knowledge of change in status leading up to 8/21/22.

On 10/4/22, I interviewed staff person 1 (SP1) by telephone. SP1 reported she worked on 8/21/22. SP1 reported in the morning Resident A was at baseline. SP1 reported later in the day, she completed an assessment and Resident A's pulse ox was low. SP1 reported the facility contacted Resident A's family and Resident A was sent to the hospital. SP1 reported this was the first time she observed a change of status. SP1 reported she was not aware that Resident A was experiencing a change of status.

On 10/12/22, I interviewed SP2 by telephone. SP2 reported she worked the days leading up to the hospitalization of Resident A. SP2 reported Resident A was not at baseline by he was sleeping more, eating less, did not want to do activities, and did not take medications. SP2 reported these concerns were not brought to anyone's attention

On 10/12/22, I interviewed SP4 by telephone. SP4 reported she provided care to Resident A on 8/20/22. SP4 reported Resident A got out of bed in the morning but did not eat breakfast. SP4 reported Resident A got back in bed and she continued to check on him. SP4 reported she did notify the facility nurse of Resident A's change in status and the direction was he was not at the level of needing medical attention. SP4 reported the following day it was determined to send Resident A out to the hospital.

On 10/22/22, I interviewed SP3 by telephone. SP3 reported she worked the days leading up to the hospitalization of Resident A. SP3 reported he was not at his baseline by he was not eating and wanted to stay in bed. SP3 reported the concerns were not brought to the oncoming shift or management.

I reviewed progress notes for Resident A. The progress notes read,

"8/21/22: Resident is alert and orient x1 with confusion, able to make some needs known. Resident was resting during AM rounds VS B/P144/65, P: 93, R: 20 T: 98.3, O2: 91%. Resident ate a few spoons of cream of wheat, resident also took AM medication with no difficulty noted. Around lunch time write was notified by caregiver that resident was nonresponsive. Writer goes into room to assess resident. Sternum rub was performed, resident made face grimace but didn't open eyes. VS BP 173/110, P: 120, T 98.3, R:20, O2:83 @2L. Covid test performed per protocol. Results: negative. Writer talked to son, and son agrees to send resident to hospital, son wants father to go to Beaumont Royal Oak. Resident was 911 out to Beaumont Farmington Hills. Son is aware father is going to Beaumont Farmington Hills hospital. Comfort and safety measures maintained."

I reviewed the medication administration record (MAR) for Resident A. The MAR revealed O2 stats were to be taken at AM, HS, Noon, and PM. The MAR revealed the following O2 stats:
9/19: 99%, 99%, 94%, 95%
9/20: 100%, 87%.

The MAR revealed no O2 stats were taken on 8/20 at AM, 8/20 at noon, and 8/21 at AM. The MAR revealed Resident A took his medications on 8/19-8/21.

I reviewed facility policy on change in resident status. The policy read,

"The community is a non-medical Community. It is the responsibility of the staff to provide care yet summon medical attention when there is a change in status.

1. *Notify the Director of Health & Wellness or Med Tech/Nurse on duty whenever there is a change in resident status.*
2. *Examples of change would include, but not be limited to:*
    a. *Refusal of meals*
    b. *Decrease mobility/range of motion*
    c. *Change in patterns of elimination*
    d. *Weakness*
    e. *Decreased coordination*
    f. *Change in level of consciousness*
    g. *Deceased communication/responsiveness*
    h. *Decreased ability to communicate*
    i. *Decline in cognitive function*
    j. *Motor agitation or retardation*
    k. *Hallucinations or other unusual behavior*
    l. *Nausea*
    m. *Vomiting*
    n. *Elevated or subnormal temperature*
    o. *Wheezing*
    p. *Shortness of breath at rest and/or on exertion*
    q. *Complaints of pain of discomfort*
    r. *Edema or swelling*

s. *Change in usual range of vital signs*
t. *Reaction/side effect to medications*
u. *Weight loss*
v. *Depressive behaviors*
w. *Exit seeking behaviors*
x. *Change in skin integrity*

3. *If there is an actual change in status or ability to function the resident's physician should be immediately notified. Always have the resident's complete chart, list of medications, current vital signs (if available) and concise list of problems*
4. *In nonemergency situations the Physician Communication form may be used. Always be sure to obtain a reply from the physician.*
5. *If this is part of an ongoing problem and home health is following the resident, contact the home health nurse and explain the situation at hand.*
6. *Document the date and time of contacts and with whom you spoke. Clearly document any new orders and repeat back to the physician.*
7. *Immediately enter the new orders on the resident's care plan and/or medication assistance record if the order pertained to medications.*
8. *Notify the resident's family/responsible person of the change in status and community action taken.*
9. *Pass on to the next shift the status change and the new physician's orders, utilizing the Med Tech to Med Tech communication log.*
10. *Document the change in status in the resident's record.*
11. *If a change in status progresses to a crisis at any time, call 911.*

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:	Interviews with multiple caregivers revealed Resident A had a change in status on or around 8/19-8/20 as observed by not wanting to get out of bed, decreased appetite, and labored breathing. However, caregivers did not appropriately follow facility policy by informing the manager on duty, the physician, and the resident's family. The facility failed to take action to ensure the health and safety of Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

The complainant reported visitation was not allowed due to a Covid-19 outbreak in the facility.

Ms. Peddy reported the facility did shut down visitation for the entire facility for one week due to an outbreak in the assisted living unit. Ms. Peddy reported the guidance came from their internal Covid-19 policies. Ms. Peddy reported the facility had a 99% vaccination rate, thirty residents in care, and seven confirmed cases of Covid-19 which put the facility in the red status and therefore visitation was shut down.

I reviewed *Center for Clinical Standards and Quality/Survey & Certification Group QSO-20-39-NH* document. The document read,

> "*While it is safer for visitors not to enter the facility during an outbreak investigation, visitors must still be allowed in the facility. Visitors should be made aware of the potential risk of visiting during an outbreak investigation and adhere to the core principles of infection prevention. If residents or their representative would like to have a visit during an outbreak investigation, they should wear face coverings or masks during visits and visits should ideally occur in the resident's room. While an outbreak investigation is occurring, facilities should limit visitor movement in the facility. For example, visitors should not walk around different halls of the facility. Rather, they should go directly to the resident's room or designated visitation area. Also, visitors should physically distance themselves from other residents and staff, when possible. Facilities may contact their local health authorities for guidance or direction on how to structure their visitation to reduce the risk of COVID-19 transmission during an outbreak investigation.*"

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents;**
For Reference: MCL 333.20201	**(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. Except for a licensed health maintenance organization, which shall comply with chapter 35 of the insurance code of 1956, 1956 PA 218, MCL 500.3501 to 500.3580, the policy shall be posted at a public place in the health facility or agency and shall be provided to each member of the health facility or agency staff. Patients or residents shall be treated in accordance with the policy.**
For Reference: MCL 333.20201	**(2) (k) A patient or resident is entitled to associate and have private communications and consultations with his or her physician or a physician's assistant to whom the physician has delegated the performance of medical care services, attorney, or any other person of his or her choice and to send and receive personal mail unopened on the same day it is received at the health facility or agency, unless medically contraindicated as documented in the medical record by the attending physician or a physician's assistant to whom the physician has delegated the performance of medical care services. A patient's or resident's civil and religious liberties, including the right to independent personal decisions and the right to knowledge of available choices, shall not be infringed and the health facility or agency shall encourage and assist in the fullest possible exercise of these rights. A patient or resident may meet with, and participate in, the activities of social, religious, and community groups at his or her discretion, unless medically contraindicated as documented in the medical record by the attending physician or a physician's assistant.**
ANALYSIS:	The facility limited visitation due to a Covid-19 outbreak. This practice limited resident's right to associate and have visitation with whom they choose. Resident rights were maintained as this law requires.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 11/16/22, I conducted an exit conference with authorized representative Michele Locricchio by telephone.

IV. RECOMMENDATION

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

10/24/22

Kimberly Horst — Date
Licensing Staff

Approved By:

11/15/2022

Andrea L. Moore, Manager — Date
Long-Term-Care State Licensing Section