GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 7, 2023

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

RE: License #: AH820399661
Investigation #: 2023A1027029
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. 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) 241-1970.

Sincerely,

Jessica Rogers

Jessica Rogers, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 285-7433
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH820399661
Investigation #:	2023A1027029
Complaint Receipt Date:	01/09/2023
Investigation Initiation Date:	01/09/2023
Report Due Date:	03/08/2023
Licensee Name:	CA Senior Northville Operator, LLC
Licensee Address:	44600 Five Mile Rd Northville, MI 48168
Licensee Telephone #:	(312) 994-1880
Administrator:	Nicole Lumberg
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:	REGULAR
Effective Date:	02/12/2022
Expiration Date:	02/11/2023
Capacity:	103
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A lacked care.	No
Resident A's medications were left unattended by staff.	Yes
Resident A missed five meals.	No
Resident A was missing clothing.	No
Resident A's patio door and refrigerator were broken, as well as her cable was not working.	No
Additional Findings	Yes

The complainant identified some concerns that were not related to licensing rules and statues for a home for the aged. Therefore, only specific items pertaining to homes of the aged provisions of care were considered for investigation. The following items were that that could be considered under the scope of licensing.

III. METHODOLOGY

01/09/2023	Special Investigation Intake 2023A1027029
01/09/2023	Special Investigation Initiated - Letter Email sent to administrator Ms. Locricchio requesting documentation pertaining to Resident A
01/10/2023	Contact - Document Received Email received from Ms. Lumberg with requested documentation
02/02/2023	Inspection Completed On-site
02/06/2023	Contact - Telephone call made Voicemail left with Employee #2
02/06/2023	Contact - Telephone call made Voicemail left with Relative A1
02/06/2023	Contact - Telephone call received Telephone interview conducted with Employee #2

02/07/2023	Contact - Telephone call received Telephone interview conducted with Relative A1
02/08/2023	Contact – Document Sent Email sent to Employee #1 requesting additional information
02/09/2023	Contact – Document Received Email received from Employee #1 with requested information
02/09/2023	Contact – Telephone call made Telephone interview conducted with Employee #1
02/09/2023	Contact – Document Sent Email sent to Employee #1 requesting additional information and documentation pertaining to Resident A
02/10/2023	Contact – Document Received Email received from Employee #1 with requested information
02/24/2023	Exit Conference Conducted with authorized representative Michele Locricchio by voicemail and email

ALLEGATION:

Resident A lacked care.

INVESTIGATION:

On 1/9/2023, the department received a complaint from Adult Protective Services (APS) which read Resident A had not received the services and care she paid for. APS did not open the allegation for investigation.

On 2/2/2023, I conducted an on-site inspection at the facility. I interviewed Employee #1 who stated Resident A received care consistent with her service plan. Employee #1 stated staff charted by exception in which the staff documented when tasks were not completed.

While on-site, I interviewed Employee #3 who stated Resident A was mostly independent with activities of daily living prior, however relied more on staff to assist now.

While on-site, I interviewed Resident A who stated, “care is good” and “staff are pleasant.” Resident A stated staff assisted when needed and she received her medications as prescribed. I observed Resident A appeared groomed and dressed in clean clothing. I observed her apartment appeared clean.

On 2/7/2023, I conducted a telephone interview with Relative A1 who stated since Resident A has resided at the facility, she has sustained a compression fracture of her spine and broken arm.

I reviewed Resident A's service plan updated on 1/25/2023 which read in part she was independent with transferring with a four-wheel walker, toileting, meals, and required no assistance with showers or grooming/personal hygiene.

I reviewed an incident report dated 1/23/2023 and submitted to the Department on 1/25/2023. The report read in part Resident A was observed on her bathroom floor and stated her fall was caused by a small hand towel on her floor. The report read in part Resident A was assessed by the nurse and was transported to the hospital for evaluation.

I reviewed the facility's progress notes dated from 4/4/2022 through 1/28/2023. Note dated 4/4/2023 read consistent with Resident A's service plan.

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:	Review of Resident A's service plan and progress notes revealed she was independent with her activities of daily living initially. Resident A's interview revealed no concerns regarding care received. There was insufficient evidence to support this allegation, thus it was not substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A's medications were left unattended by staff.

INVESTIGATION:

On 1/9/2023, the department received a complaint from Adult Protective Services (APS) which read Resident A's medications were left on her counter on 1/8/2023. APS did not open the allegation for investigation.

On 2/2/2023, I conducted an on-site inspection at the facility. I interviewed Employee #1 who stated Resident A had previously administered her own medications, however now staff administered them. Employee #1 stated staff were trained to stay with residents until they took their medications.

While on-site, I interviewed Resident A who stated staff administered her medications consistently, however one time her medications were left in the cup next to her microwave. I observed Resident A's room in which there were no medications identified.

On 2/6/2023, I conducted a telephone interview with Employee #2 who stated she heard medications were left in Resident A's apartment but had not observed it herself. Employee #2 stated that staff member who left the medication in Resident A's apartment no longer worked for the facility. Employee #2 stated when she administered resident's medications, she always observed the resident take the medications and never left them at bedside. Employee #2 stated staff are trained to observe residents take their medications.

On 2/7/2023, I conducted a telephone interview with Relative A1 who stated Resident A had a cup of medication left in her room in which the nurse duty observed and took the medications from her room.

On 2/7/2023, I conducted a telephone interview with Employee #3 who stated she had observed a medication cup in Resident A's apartment with approximately four pills. Employee #3 stated she took the medication from Resident A's apartment and informed Employee #1 so follow-up could be completed. Additionally, Employee #3 stated she questioned Employee #2 who stated she had administered Resident A's medications that morning in which she observed her take them.

On 2/9/2023, email correspondence with Employee #1 read "*With the medication being left in her room once notified I tried to rectify how medication was left behind and educated staff that [Resident A] does not administer her medications and they shouldn't be left there."*

I reviewed Resident A's service plan updated on 1/25/2023 which read in part "*The (community administers medication(s) / the resident self-administers medications(s)) per physician orders. Staff to report to nurse if [Resident A] has changes in ability to take medications as prescribed.*"

On 2/9/2023, I conducted a telephone interview with Employee #1 in which she stated staff administered Resident A's medications except for her as needed "Tums."

I reviewed Resident A's January 2023 medication administration records (MARs) which read staff initialed Resident A's medications administered on 1/7/2023 and 1/8/2023. The MAR read Calcium Carbonate (Tums) 750 mg by mouth, take two tablets as needed and okay to have at bedside.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(5) A home shall take reasonable precautions to ensure or assure that prescription medication is not used by a person other than the resident for whom the medication is prescribed.
ANALYSIS:	Staff attestations and documentation revealed staff were to administer Resident A's medications, except for Tums. Additionally, staff and Resident A's attestations revealed medications were left unattended in her apartment, thus the facility did not take reasonable precautions to ensure the medications were not used by another person. Based on this information, this allegation was substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A missed five meals.

INVESTIGATION:

On 1/9/2023, the department received a complaint from Adult Protective Services (APS) which read Resident A had not received five meals during a COVID-19 lockdown. The complaint read Resident A alerted staff that she had not eaten and about 2-3 hours passed before she received a meal. The complaint read on one occasion a staff member obtained food for Resident A from a fast-food restaurant. APS did not open the allegation for investigation.

On 2/2/2023, I conducted an on-site inspection at the facility. I interviewed Ms. Lumberg who stated during the COVID-19 outbreak from 12/28/2023 to 1/8/2023, residents received meals in their rooms. Ms. Lumberg stated staff were notified after the kitchen was closed that Resident A's meal was not delivered so staff purchased a meal from a local restaurant. Ms. Lumberg stated Resident A received her meals later than usual times.

While on-site, I interviewed Employee #1 who stated Resident A was sometimes a late eater in which the kitchen would need to special prepare items such as pancakes.

While on-site, I interviewed Resident A stated when delivering meals to rooms during the COVID-19, “they (staff) would miss me.” Resident A stated she pushed her call pendent and staff would bring her a meal.

On 2/7/2023, I conducted a telephone interview with Relative A1 who stated Resident A received meals during the COVID-19 lockdown, however there were several instances when her meals were not delivered by staff in which she was required to push her pendant to request them. Relative A1 stated residents were required to stay in their apartments and were unable to obtain food unless it was brought to them.

I reviewed Resident A’s admission contract dated 3/31/2022 which read in part the facility offered snacks and three meals daily.

I reviewed Resident A’s service plan updated on 1/25/2023 which read consistent with her admission contract. The plan read in part Resident A did not require support with eating.

I reviewed the facility’s meal census dated from 12/28/2022 through 1/8/2023. The meal census listed the facility’s residents with their room numbers, as well as a column for breakfast, lunch and dinner in which staff checked if residents received their meals. The meal census read Resident A had received three meals per day. Meal census dated 12/28/2023 for Resident A read “R” for breakfast and checked that she received lunch and dinner. Meal census dated 1/6/2023 read Resident A was “out” for the dinner meal. Meal census dated 1/7/2023 read Resident A received “takeout” for her dinner meal. The 1/7/2023 meal census read three other residents also received “takeout.”

APPLICABLE RULE	
R 325.1952	**Meals and special diets.**
	(1) A home shall offer 3 meals daily to be served to a resident at regular meal times. A home shall make snacks and beverages available to residents.

ANALYSIS:	Review of Resident A's admission contract and service plan revealed the facility was to offer three meals per day. Although it could not be confirmed the exact delivery times of Resident A's meals nor how Resident A "missed" delivery of her meals, review of facility documentation revealed the facility offered her three meals per day during the COVID-19 outbreak. Resident A's interview revealed she was required to request meals by utilizing her pendant in which it would be prudent for facility staff delivering meals to ensure all residents received them during "lockdown" periods, nonetheless, this allegation could not be substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A was missing clothing.

INVESTIGATION:

On 1/9/2023, the department received a complaint from Adult Protective Services (APS) which read Resident A had missing clothing after staff completed the laundry. APS did not open the allegation for investigation.

On 2/2/2023, I completed an on-site inspection at the facility. I interviewed administrator Nicole Lumberg who stated she was not aware Resident A was missing clothing. Ms. Lumberg stated staff completed every resident's laundry individually in which if they were misplaced, staff attempted to locate any missing items.

While on-site, I interviewed Employee #1 who stated staff returned items from laundry to Resident A's apartment in which she was not able to locate the item. For example, Employee #1 stated staff returned Resident A's clean sheets to her closet, and she could not locate them. Employee #1 stated staff had not identified any missing items from the laundry for Resident A.

While on-site, I interviewed Resident A who stated she was missing a pair of pants and her University of Michigan graduation ring. Resident A stated staff helped her look for the missing items but were unable to locate them.

On 2/7/2023, I conducted a telephone interview with Relative A1 who stated Resident A was missing several pieces of clothing in which they bought her new clothing. Relative A1 stated Employee #1 was able to locate some of the clothing in other resident's apartments, but her ring was never located.

I reviewed Resident A's admission contract dated 3/31/2022 which read in part:

> ***"RESPONSIBILITY FOR PERSONAL PROPERTY.*** *You shall provide all items for Your personal use, including, but not limited to clothing, toiletry equipment and supplies. Personal items may not be used if they threaten the health, safety, or welfare of other residents or if they in any way infringe on the rights of other residents. The Residence is not responsible for loss of property belonging to You due to theft or any other cause unless such loss is caused by the negligent or intentional acts of the Residence or its employees or agents. The Residence again strongly recommends that You independently purchase and maintain renter's or liability insurance to cover loss or damage to Your personal property."*

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:	Interview with Resident A and Relative A1 revealed there was missing clothing and a ring. Staff attestations revealed staff assisted with trying to locate missing personal items for Resident A. Review of Resident A's admission contract revealed the facility was not responsible for loss of personal items, thus this allegation was not substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A's patio door and refrigerator were broken, as well as her cable was not working.

INVESTIGATION:

On 1/9/2023, the department received a complaint from Adult Protective Services (APS) which read Resident A's patio door had been broken for five months and was holding on by one hinge. The complaint read Resident A refrigerator was not working properly and did not keep items cold. The complaint read Resident A's cable

television was out for two months in her bedroom and was part of her fee. APS did not open the allegation for investigation.

On 2/2/2023, I conducted an on-site inspection at the facility. I interviewed Ms. Lumberg who stated Resident A's son had emailed her on 1/10/2023 regarding the broken patio door and refrigerator. Ms. Lumberg stated the maintenance director fixed the patio door and replaced the refrigerator that same day. Ms. Lumberg stated she spoke with Resident A's son by telephone later that day to let him know those items were fixed. Ms. Lumberg stated residents could let staff or the front desk staff person/concierge know about broken items in which a work order would be entered into the system for the maintenance director to fix the items. Ms. Lumberg stated there were no work orders for Resident A's broken items since they were fixed immediately.

While on-site, I interviewed Resident A who stated she reported both the broken refrigerator and patio door to the staff person at the front desk multiple times. Resident A stated she could not remember the staff person's name. Resident A stated both items were broken for "quite a while." Resident A stated both items were fixed recently after her son spoke with the facility staff.

While on-site, I observed the bottom hinge of Resident A's door had wood missing from it in which had appeared the hinge was replaced. I observed Resident A's refrigerator which appeared new. I observed the thermometer in the freezer read 0 degrees Fahrenheit and, in the refrigerator, read 38 degrees Fahrenheit. I observed Resident A's one channel on her living room television.

While on-site, I observed Ms. Lumberg speaking with Resident A and her son, in which her son stated she was not working the television remotes correctly, so the cable was working appropriately in her apartment.

On 2/6/2023, I conducted a telephone interview with Relative A1 who stated he had verbalized the broken patio door and refrigerator to Employee #1 months ago. Relative A1 stated he and Resident A followed up to inquire about the status of the broken items in which they were told a work order had been submitted. Relative A1 stated the items were eventually fixed however there was never a work order placed months prior. Relative A1 also stated the cable had not worked for two months last year as well.

On 2/9/2023, email correspondence with Employee #1 read *"Prior to the written notification sent to [Ms. Lumberg] in January I was not verbally made aware of any issues pertaining to [Resident A's] patio door, refrigerator or cable television."*

I reviewed Resident A's admission contract dated 3/31/2022 which read in part:

> *"**Utilities.** The Residence furnishes Your Apartment with water, electricity, heat, and cable television outlets. Cable service and local and/or long distance*

telephone service will be available to You as listed on Appendix C, Optional Services."

The contract's Appendix C read in part basic cable was provided "*as available at cost, per cable contract agreement at specific community."*

APPLICABLE RULE	
R 325.1979	**General maintenance and storage.**
	(1) The building, equipment, and furniture shall be kept clean and in good repair.
ANALYSIS:	Observations of Resident A's patio door and refrigerator revealed they were fixed and in working order at the time of inspection. Additionally, Resident A's cable television was working appropriately. Interviews with both Resident A and Relative A1 revealed verbal notification to staff and the facility lacked work orders, thus there was insufficient documentation to support the allegation and it was not substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

While on-site at the facility on 2/2/2023, I observed Resident A was wearing a sling on her left arm. Resident A stated she had fallen in which her arm was painful, and she was going to a doctor's appointment for follow up.

While on-site, interview with Employee #3 revealed Resident A was mostly independent with activities of daily living prior, however relied more on staff to assist now.

Review of an incident report dated 1/23/2023 read consistent with statements from Resident A.

Review of Resident A's service plan updated on 1/25/2023 read she was independent with transferring with a four-wheel walker, toileting, meals, and required no assistance with showers or grooming/personal hygiene.

Review of Resident A's progress notes revealed Resident A returned from the hospital with her left arm in a sling due to a fractured humerus on 1/23/2023. Note dated 1/23/2023 read in part Resident A would be needing more assistance than usual. Note dated 1/26/2023 read in part Resident A was requiring a little more assistance.

APPLICABLE RULE	
R 325.1922	**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:	Interview with Resident A along with observations and facility documentation revealed she had a fall with injury which required her to need more assistance from staff. Review of Resident A's service plan read she was independent with care. The plan lacked specific care and instruction for staff to provide additional assistance for Resident A, thus a violation was substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

I recommend the status of this license remain unchanged.

02/13/2023

Jessica Rogers Date
Licensing Staff

Approved By:

02/24/2023

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