GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 7, 2023

Michele Locricchio
Anthology of Rochester Hills
1775 S. Rochester Rd
Rochester Hills, MI 48307

RE: License #: AH630398529
Investigation #: 2023A1019029
Anthology of Rochester 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. 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 #:	2023A1019029
Complaint Receipt Date:	02/27/2023
Investigation Initiation Date:	02/27/2023
Report Due Date:	04/29/2023
Licensee Name:	CA Senior Rochester Hills Operator, LLC
Licensee Address:	1775 S. Rochester Rd Rochester Hills, MI 48307
Licensee Telephone #:	(312) 248-2091
Administrator:	Michael Hamid
Authorized Representative:	Michele Locricchio
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:	11/13/2022
Expiration Date:	11/12/2023
Capacity:	105
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Physical abuse to Resident A.	Yes
Additional Findings	No

III. METHODOLOGY

02/27/2023	Special Investigation Intake 2023A1019029
02/27/2023	Comment The complaint was forwarded to LARA from APS; LARA will not be submitting an APS referral since they are aware of the allegations.
02/27/2023	Special Investigation Initiated - Letter Emailed AR requesting documentation.
03/02/2023	Comment Area manager approved investigation to be conducted remotely.
03/02/2023	Inspection Completed-BCAL Sub. Compliance

ALLEGATION:

Physical abuse to Resident A.

INVESTIGATION:

On 2/27/23, the department received a complaint alleging that on 2/22/23, Resident A was struck on the arm with a closed fist multiple times by Employee 1.

On 2/22/23, licensing staff was onsite for a separate investigation when administrator Michael Hamid notified this writer about an abuse incident that occurred involving Resident A and Employee 1. Mr. Hamid reported during that onsite that Resident A's family and law enforcement were aware and that an incident report would be forthcoming. Mr. Hamid reported that Employee 1 was suspended immediately and was ultimately terminated.

On 2/23/23, Mr. Hamid submitted an incident report that read:

Care Manager A and Care Manager B escorted resident to her apartment to be changed as they were doing their change over rounds. Care Manager A and Care Manager B were transferring resident from her wheelchair to the bed. Care Manager A told Care Manager B to be more gentle when he transfers the resident because she is fragile. As they both continued to provide care to the resident, Care Manager B roughly turned the resident on the side and ripped the residents clothing off. The resident was yelling at him to stop being so rough. Care Manager B told her to "shut up and stop screaming" and proceeded to hold her hands down and punch her left arm. Care Manager A told Care Manager B that he cannot physically hit the residents and that she would finish getting her dressed. Care Manager A did not want to leave the resident alone with Care Manager B so she stayed until they finished getting the resident dressed. Immediately after, Care Manager A told the Medication Manager what she observed. Care Manager B had already clocked out and went home at this point as their shift was over. Medication Manager notified Director of Virtue (DOV). Director of Virtue had Care Manager A write a statement. DOV notified Director of Health and Wellness (DHW) and Executive Director (ED) of the incident. Executive Director called Care Manager B and suspended him immediately pending investigation and asked him to write a statement. Director of Health and Wellness went to memory care and interviewed the resident and completed a skin assessment. Resident stated to DHW that she felt like Care Manager B was intentionally being rough with her and punched her in the left arm. Resident also stated that she was scared he would come back and retaliate after she told the truth. DHW assured resident that Care Manager B will not come back to harm her again. Skin assessment was completed and there was bruising on her left arm and wrist noted. Resident did not complain of any pain.

After internal investigation was completed, Executive Director called the Oakland County Sheriff's office on 2/23/2023 to file a police report. Deputy arrived to the community and conducted an investigation. Care Manager A and resident were both interviewed. Resident was unable to remember what happened the day before. Care Manager A was able to provide a full statement of the situation. Report number: 23-0044883.

Dr. Rojas, Medical Director of In House Hospice came to evaluate resident to ensure she was stable and did not need medical treatment outside of the community. Dr. Rojas stated that the resident did not show any signs of distress or pain and did not need any follow up medical treatment.

Resident is A&Ox1 and uses a Geri Chair to be escorted everywhere.

Mr. Hamid obtained written statements from Employees 1, 2, 3, 4 and 5, which are summarized as follows:

- Employee 1 denied any inappropriate encounter with Resident A, including the assault.
- Employee 2 attested that she observed Employee 1 being rough with Resident A and punching her in the arm. Employee 2 reported that following the incident, she notified Employee 3.
- Employee 3 verified that Employee 2 informed her of what she witnessed and then Employee 3 reported that she called Employee 4 to notify her of what happened.
- Employee 4 attested that Employee 3 reported the encounter to her and reported that she then called Mr. Hamid to notify him and also called Employee 5 for notification purposes. Employee 4 attested that Mr. Hamid stated that Employee 1 would be suspended immediately. Employee 4 reported that Employee 5 was responsible for examining Resident A.
- Employee 5 attested that Resident A directly told her that Employee 1 grabbed and hit her left arm and felt threated to be alone with him. Employee 5 attested that she observed redness and swelling to Resident A's left arm and wrist.

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. 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)(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 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. In case of a chemical restraint, a physician shall be consulted within 24 hours after the commencement of the chemical restraint.
ANALYSIS:	Employee 2 directly witnessed Employee 1 physically assaulting Resident A. Resident A was assessed and injuries were found consistent with Employee 2's attestation. Employee1 treated Resident A in a manner that is inconsistent with the provision of care outlined in this statute. Staff also failed to notify law enforcement at the time of becoming aware of the incident; a call was not placed until the following day.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

03/03/2023

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Elizabeth Gregory-Weil Date
Licensing Staff

Approved By:

03/07/2023

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