GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 26, 2023

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

RE: License #: AH630402476
Investigation #: 2023A1019035

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 #:	AH630402476
Investigation #:	2023A1019035
Complaint Receipt Date:	04/03/2023
Investigation Initiation Date:	04/04/2023
Report Due Date:	06/03/2023
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:	REGULAR
Effective Date:	09/30/2022
Expiration Date:	09/29/2023
Capacity:	120
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A did not receive medications as prescribed.	Yes
Additional Findings	Yes

III. METHODOLOGY

04/03/2023	Special Investigation Intake 2023A1019035
04/04/2023	Special Investigation Initiated - Letter Emailed administrator K. Peddy for documentation, correspondence is ongoing.
04/04/2023	APS Referral
04/07/2023	Inspection Completed BCAL Sub. Compliance

ALLEGATION:

Resident A did not receive medications as prescribed.

INVESTIGATION:

On 4/3/23, the department received a complaint alleging numerous medication issues involving Resident A. The complaint alleged that Resident A was not given any doses of Lactulose on 1/21/23 and did not receive his morning medications on 1/22/23. The complaint read that Midodrine was administered when it should not have been based off of his blood pressure and it is alleged that Amoxicillin and eye drops were not administered as ordered. The complaint read that Resident A moved into the facility on 1/3/23 and passed away on 2/12/23.

In follow up correspondence with the administrator Kelleigh Peddy, I requested copies of Resident A's medication orders, medication administration records and progress notes for the duration of his tenancy at the facility. A progress note documented read that on 1/22/23, Resident A was sent to the hospital for "faint speech when given verbal cues", however Resident A never returned to the facility. Additional progress note documentation indicates that he was discharged from the hospital directly to a hospice facility.

Resident A's medication administration records (MAR) were reviewed. I observed that Resident A did not receive one or more scheduled doses of Amoxicillin on the

following dates: 1/17/23 (two missed doses), 1/18/23 (three missed doses), 1/19/23 (three missed doses), 1/20/23 (three missed doses) and 1/21/23 (three missed doses). On 1/18/23, staff notated “order” as to indicate that the medication was or needed to be reordered. On 1/19/23, staff notated “not ava” as to indicate that the medication was not available. On 1/20/23, staff notated “waiting” as to indicate that they were waiting for the medication to arrive at the facility.

I observed that Resident A did not receive one or more scheduled doses of Cequa Ophthalmic Solution on the follow dates: 1/4/23 (one missed dose), 1/5/23 (one missed dose), 1/6/23 (two missed doses), 1/7/23 (two missed doses) and 1/21/23 (one missed dose). On 1/4/23, staff notated “ordered” as to indicate that a refill had been requested. On 1/5/23, staff notated “med not here”. On 1/6/23, staff notated “reordered” and on 1/7/23, staff documented “ordered” again. I observed that staff documented that this medication was administered to Resident A on the evening of 1/5/23, which was in-between doses in which staff indicated that the medication was not available. It is reasonable to assume that this is a documentation error.

I observed that Resident A did not receive one or more scheduled doses of FeroSul on the following dates: 1/5/23 (one missed dose), 1/10/23 (two missed doses), 1/14/23 (one missed dose) and 1/21/23 (one missed dose). On 1/5/23, staff notated “med not here”.

I observed that Resident A did not receive one scheduled dose of Lactulose Oral Solution on 1/21/23. Staff failed to document a reason as to why the dose was missed.

I observed that Resident A missed one or more scheduled doses of Pantoprazole on the following dates: 1/17/23 (one missed dose), 1/18/23 (one missed dose), 1/20/23 (one missed dose) and 1/21/23 (one missed dose). On 1/18/23, staff notated “reorder” as to indicate that the medication was or needed to be reordered.

Lastly, Resident A is prescribed Midodrine with the instruction “Take 1 tablet by mouth every 8 hours *Hold for SBP>140”. I observed that Resident A’s systolic blood pressure was greater than 140 on the following dates: 1/5/23 (149/64 during the evening vital check), 1/7/23 (159/69 during the afternoon vital check), 1/8/23 (141/90 during the evening vital check), 1/10/23 (161/114 during the morning vital check, 161/88 during the afternoon check and 158/83 during the evening vital check) and 1/11/23 (142/69 during the evening vital check). Review of Resident A’s MAR shows that staff documented administering the medication on all of the above instances despite the physician’s instruction to withhold it. On the following dates, staff failed to record Resident A’s blood pressure: 1/4/23 (no record of morning and afternoon vital checks), 1/13/23 (no record of the afternoon vital check), 1/14/23 (no record of the afternoon vital check), 1/16/23 (no record of the afternoon vital check), 1/18/23 (no record of the afternoon vital check), 1/19/23 (no record of the afternoon vital check) and 1/20/23 (no record of the afternoon vital check). Resident A’s MAR reveals that

staff administered the medication during instances in which staff failed to record his blood pressure, therefore it is unknown if the medication was safe for him to take. I also observed that Resident A did not receive one or more scheduled doses of Midodrine on the following dates: 1/4/23 (one missed dose), 1/12/23 (two missed doses), 1/20/23 (one missed dose) and 1/21/23 (one missed dose). On 1/4/23, staff notated “resident sleeping” as the reason for the missed dose. There is no evidence that staff attempted to administer the medication to the resident upon waking. On 1/12/23, staff notated “held” as to indicate that his blood pressure was out of range to safely administer the medications. Staff failed to document any reason to justify the missed doses on 1/20/23 and 1/21/23.

In follow up correspondence with Ms. Peddy, she made the following remarks:

- For Resident A’s Amoxicillin, Ms. Peddy reported that the order was for a seven day supply and that didn’t discharge the medication in the electronic medical record system (eMAR) when the dose was complete. Ms. Peddy provided a copy of the physician’s order for this medication which did confirm it was for seven days.
- For Resident A’s Cequa solution, Ms. Peddy reported that Resident A arrived at the facility with only one dose of the medication left and that the facility had to reorder it. Ms. Peddy was unable to provide evidence that the medication was ever reordered and/or delivered to the facility and reports that she assumes that Resident A’s family brought in the medication.
- Ms. Peddy had no justification for Resident A’s missed FeruSol.
- For Resident A’s Pantoprazole, Ms. Peddy reported that the medication was reordered on 1/17/23 and it was delivered to the facility on 1/18/23. She also reported that the facility’s eMAR system has restrictions as to the times that staff can document med passes and reported that for the missed dose on 1/20/23 staff were unable to document that the medication was given. There was no additional justification for the missed dose on 1/21/23.
- Ms. Peddy had no justification for staff’s negligence in administering Midodrine when it should not have been. Ms. Peddy reported that the med techs who made this error were pulled off of the medication carts and retrained.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(2) Prescribed medication managed by the home shall be given, taken, or applied pursuant to labeling instructions, orders and by the prescribing licensed health care professional.

ANALYSIS:	On numerous occasions, staff failed to ensure that Resident A was administered medications per physician's orders.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING:

Ms. Peddy reported that the facility's eMAR system does not allow staff to document medication passes if the administration time occurs outside of the assigned administration window. Ms. Peddy confirmed that there are times that staff cannot document when they give medications due to the parameters of their medical record system.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(3) Staff who supervise the administration of medication for residents who do not self-administer shall comply with all of the following: **(iv) The time when the prescribed medication is to be administered and when the medication was administered.** **(v) The initials of the individual who administered the prescribed medication.**
ANALYSIS:	Per the administrator, the facility's electronic medical record system prevents staff from documenting medication passes in real time depending on the actual administration time of the medication. Therefore, there are many instances in which staff are unable to document when they give the medication at the time it is given.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

04/12/2023

Elizabeth Gregory-Weil Date
Licensing Staff

Approved By:

04/26/2023

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