GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

August 21, 2023

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

RE: License #: AH630402476
Investigation #: 2023A1035005
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) 241-1970.

Sincerely,

Jennifer Heim, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(313) 410-3226

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630402476
Investigation #:	2023A1035005
Complaint Receipt Date:	06/12/2023
Investigation Initiation Date:	06/15/2023
Report Due Date:	08/14/2023
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:	Michael Hamid
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 not being monitored.	Yes
Additional Findings	No

III. METHODOLOGY

06/12/2023	Special Investigation Intake 2023A1035005
06/15/2023	Special Investigation Initiated - Letter An email requesting additional information sent to Administrator Kelleigh Peddy and Authorized Representative Michele Locricchio
6/16/2023	Contact - Document Received Email received from executive director with additional information.
6/23/2023	Inspection Completed On-site
6/23/2023	Contact- Documents Received Email received with Resident A progress notes, service plan, behavior log, and incident report.
8/8/2023	Contact- email requesting incident reports from 6/2/2023 and 6/4/2023, and 72-hour post fall documentation.
8/9/2023	Contact- Document Received Assigned APS worker emailed investigation and findings
8/9/2023	Contact - Document Received Email received from executive director stating, “alert charting was not initiated.”
8/9/2023	Contact- Document Requested Camera footage/ timeline outline requested
8/10/2023	Document Received – camera footage/ timeline and policy related to rounding frequency
8/21/2023	Exit Conference Conducted by phone and email with authorized representative Ms. Locricchio

ALLEGATION:

Resident A not being monitored.

INVESTIGATION:

On 06/12/2023**,** the licensing unit received a complaint with allegations stating. “On 06/02/23, Resident A family went to visit her at Anthology but could not locate her. She was found on the floor in memory care in another resident's room. Anthology staff was unaware how Resident A got there, on 06/04/23, Resident A had a second unwitnessed fall. Resident A is in memory care to be watched 24/7 and she is not being watched at the facility.”

On 6/15/2023, I sent an email to Michele Locricchio authorized representative requesting facility policies and procedures related to falls, employee roster, and client care guide for Resident A.

On 6/16/2023 I received requested information related to policies and procedures for falls, employee roster, and client care guide. The fall policy stated: *in the event a resident falls the caregiver are instructed to summon immediate assistance, do not move resident, inspect bleeding or obvious deformities, call emergency medical services if trauma is noted.*

On 6/23/2023 I conducted an on-site inspection at the facility. I interviewed executive director Michael Hamid. Mr. Hamid was able to review facility policies and procedures related to falls and the fall incidents that occurred with Resident A on 6/2/2023 and 6/4/2023. June 2, 2023, incident report read: “*As med tech came onto shift, med tech completed rounds. while completing rounds, staffed observed resident in another residents apartment laying on the floor. Resident was observed laying in resident's bedroom area in front of recliner chair next to the window. Med Tech called for assistance as resident appears to have a large lump on the right side of her head. Resident says she was not in pain but acknowledged that she hit her head. Med Tech assessed the resident and called EMS for assistance and additional assessment. EMS came and transferred her to Henry Ford West Bloomfield Hospital*.” During record review it was noted Resident A client care guide was updated on 6/2/2023 with fall intervention “*1:1 with resident while wandering*”. It was noted through record review on 6/4/2023 Resident A was observed on the hallway floor around 1940, caregivers were not with Resident A during this time of wandering, emergency services called, and resident was sent to the hospital. Mr. Hamid reported Resident A returned to the facility with new interventions of “continued increased wellness checks while in bed as well as encourage floor padding for increased safety.”

On 6/23/2023 Interviewed staff person (SP)1 at the facility. SP1 stated Resident A has had a decline, becomes aggressive at times, during periods of aggression she requires two-person assistance. SP1 stated Resident A is a one person assist when calm and redirectable. SP1 stated eyes are placed on each resident every 1-2 hours in the event a resident is not seen all staff start looking for the missing resident.

On 06/23/2023, I observed approximately, three staff members engaged with residents during interview with SP1.

On 06/23/2023, while on-site I observed Resident A calmly sitting in common area with other residents. I attempted to interview Resident A, but due to cognitive impairments Resident A was unable to answer basic questions.

On 8/8/2023, I requested additional documentation: Resident A incident reports for the fall that occurred on 6/2/2023 and 6/4/2023, rounding policy, and 72-hour post fall charting as stated in policy. June 2, 2023, incident report read: "*As med tech came onto shift, med tech completed rounds. while completing rounds, staffed observed resident in another residents apartment laying on the floor. Resident was observed laying in resident's bedroom area in front of recliner chair next to the window. Med Tech called for assistance as resident appears to have a large lump on the right side of her head. Resident says she was not in pain but acknowledged that she hit her head. Med Tech assessed the resident and called EMS for assistance and additional assessment. EMS came and transferred her to Henry Ford West Bloomfield Hospital*." June 4, 2023 incident report read *"Writer was paged to virtue for an emergency. Upon arrival on scene 3 floor med tech and care staff reported that resident was observed on the floor. Med tech and care staff had assisted resident from the floor to her wheelchair. Care staff stated that "she had assisted resident to bed not to long ago and went on to the next room to provide care. While Walking down the hallway, that is when she noticed resident was laying back flat on the floor mat next to her bed and called for help immediately." Resident is A&O x1 with confusion. VS were 128/89, P-86, Temp- 98.2, R-16 , Spo2 on RA 94%. No bleeding or open wound was noted. Resident c/o right head pain on the same side she has a bruise from a pervious fall. On Call supervisor and Family was notified and resident was send out to Henry Ford for further eval. Resident left community with EMS at 7:56pm."* Mr. Hamid stated resident returned to the community and 72-hour charting/ "alert charting" was not initiated.

On 8/9/2023, BSHS complaints referred to APS, assigned APS worker had sent an email with her investigation and finding. After reviewing APS finding it was noted there was an outline of facility camera footage provided by previous facility administrator. I reached out Mr. Hamid requesting the outline of camera footage related to the fall that occurred on 6/2/2023.

On 8/10/2023, I received the outline of camera footage. Outline stated on 6/2/2023 family arrived at Anthology of Farmington Hills and was unable to locate Resident A. staff assisted family in locating Resident A. Resident A was observed on the floor in another resident's room. Med Tech contacted emergency medical services. Staff was unaware of how long Resident A had been on the floor. Mr. Hamid reported upon review of outlined facility camera footage conducted by previous executive director it was noted that Resident A entered other residents' room at 1420 and was observed on the floor at 1612. Resident monitoring policy states "*Resident whereabouts will be monitored to minimize the potential for elopement from memory*

care while allowing for resident independence and dignity. A systematic approach for resident monitoring will be provided with routine staff rounds. Shift overlap time or "change in shift" time will include an additional accounting of all residents. All residents will be visually confirmed to account for each resident's whereabouts."

APPLICABLE RULE	
R 325.1931(2)	**Employee; 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 service plan.
ANALYSIS:	Though policy and record review it was noted the facility followed facility policy related to falls. On 6/2/2023 Resident A was observed on the floor with an injury to head, assistance was requested, emergency services were contacted, Resident A was sent to local hospital for further evaluation, and Resident A returned to the facility. On 6/4/2023, Resident A was observed on the floor in the hallway and caregiver called for assistance, assistance rendered, emergency services were contacted, Resident A was sent to hospital for further evaluation, and Resident A returned to home. Resident A had a fall at the facility on 06/02/2023. Following the fall, Resident A's service plan was updated to state, "1:1 during times of wandering." Review of incident report revealed on 06/04/2023, Resident A was seen wandering without 1:1 care. Therefore, the facility did not appropriately follow Resident A's service plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of this license remain unchanged.

_____08/21/2023_____
Jennifer Heim Date
Licensing Staff

Approved By:

08/21/2023

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