GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

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

October 17, 2023

RE: License #: AH820399661
Investigation #: 2023A1022014
Anthology of Northville

Dear Michele 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.

Please review the enclosed documentation for accuracy and contact me with any questions.

Sincerely,

Barbara P. Zabitz, R.D.N., M.Ed.
Health Care Surveyor
Health Facility Licensing, Permits, and Support Division
Bureau of Community and Health Systems
Department of Licensing and Regulatory Affairs
Mobile Phone: 313-296-5731
Email: zabitzb@michigan.gov

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH820399661
Investigation #:	2023A1022014
Complaint Receipt Date:	11/14/2022
Investigation Initiation Date:	11/15/2022
Report Due Date:	01/14/2023
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:	02/12/2023
Expiration Date:	02/11/2024
Capacity:	103
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
An employee did not follow the service plan when providing care for the Resident of Concern (ROC), resulting in an injury.	Yes
The facility did not follow-up with the ROC regarding possible injuries after she fell.	No
The facility did not maintain equipment in a safe condition.	No
Additional Findings	Yes

III. METHODOLOGY

11/14/2022	Special Investigation Intake 2023A1022014
11/15/2022	Special Investigation Initiated - Telephone Phone call made and email sent.
02/24/2023	APS Referral
02/24/2023	Inspection Completed On-site
05/05/2023	Contact - Document Received Email exchange with facility
05/09/2023	Contact - Telephone call made. Interview with caregiver #1.
10/17/2023	Exit Conference

ALLEGATION:

An employee did not follow the service plan when providing care for the Resident of Concern (ROC), resulting in an injury.

INVESTIGATION:

On 10/30/2022, the Bureau of Community and Health Systems received a complaint that read in part, "…On 10/29/22 Mom (the Resident of Concern/ROC) was discharged from St. Mary's Hospital in Livonia after a second fall at Anthology of Northville… A granny cam (remote video camera system) replay of 10/28/22 shows Mom was not settled back into a stable position in her wheelchair or bed after being returned to her room following a movie presentation in the theater. Mom, who is on two blood thinners, fell out of her chair and hit her head. Video shows no response for over 30 minutes…Mom was discovered on the floor by an aide, who told [name of family member #1] on 10/29/22 that her wheelchair was missing the right arm support and the brake was not on when she discovered Mom. In addition, video shows Mom's legs were not extended, which helps with circulation and might have deterred the fall with a counterbalance… (October 28) …(at) 3:55p. Movie time is over. [Name of activities employee], the activities aide, wheels Mom to her room… He does not position Mom, check her wheelchair for stability, or settle her into her room as usual (with her tray table on her only good side, the right side) … (at) 4:09:18p. Granny cam replay shows Mom has been left in her wheelchair in a dangerous position, with her legs down (rather than extended as prescribed for circulatory reasons). Also, the wheelchair back is tilting forward at less than 90 degrees. Finally, the aide who found her on the floor said the right arm support was missing from the wheelchair and the brake was not on. Mom drops a pillow from her chair falls trying to pick it up; her head hits the wall; see video replay. Mom lies there on the floor until 4:40p -- 31 minutes… (at) 4:40p. Aide named [name of caregiver] comes in and finds Mom on the floor, on her right side…"

On 11/21/2022, I interviewed family member #2, the complainant, and family member #1 by phone. Family members #1 and #2 stated that they did not believe that the facility was doing as much as possible to keep the ROC from injury, especially when it came to the staff members following the ROC's service plan. They reiterated that that the activities aide who escorted the ROC back to her room did not elevate her feet and did not apply the wheelchair brake. They alleged that they were not informed that wheelchair's right arm rest was missing until after the ROC fell. This was very concerning to the ROC's family, mainly because the ROC had sustained a fall with a resultant fracture in June 2022, when staff did not follow the service plan direction for a two-person transfer into her wheelchair.

On 2/24/2023, a referral was made to Adult Protective Services.

At the time of the onsite visit, 2/24/2023, I interviewed both the administrator and the wellness director. When asked about the ROC, while both the administrator and the wellness director knew the ROC and the ROC's family, neither of them remembered enough about the incident of 10/28/2022 to be able to talk about it without referring to notes.

On 5/5/2023 via an email response, the wellness director reported that the facility's review of notes pertaining to the ROC indicated that the fall sustained on 10/28/2023 was "due to resident reaching to grab an object from the floor i.e (napkin or ink pen)." In response to the allegations that the wheelchair brakes had not been applied and that the right arm rest was missing, the wellness director stated that neither of these allegations were true, that the "wheelchair brakes were on, resident's right arm rest was not missing." The wellness director did not respond to the allegation that the ROC's footrests had not been elevated when the ROC was brought back to her room.

On 5/9/2023, I interviewed caregiver #1, who was the staff member who found the ROC on the floor, in her room on 10/28/2022. Caregiver #1 stated that the wheelchair brakes had been applied to the ROC's wheelchair and that the wheelchair itself was intact. Caregiver #1 stated that the footrests were on the wheelchair but did not describe the positioning of the foot rests, whether they were in the down position or if they were elevated.

Review of the ROC's charting notes revealed that on 10/28/2022, the wellness director documented, "Resident observed on floor on right side of body near wheelchair. Assessed by writer and care staff for bruises. No bruises or abnormalities noted. Daughter [name of family member #1] notified and MD notified…"

Review of the ROC's service plan indicated that staff were to ensure that the footrests on the ROC's wheelchair were extended, so that her legs were elevated. Staff were also to ensure that the wheelchair brakes were locked, whenever the wheelchair was not in motion as well as to "park" the wheelchair "with her right side fully accessible to the dining room table and her side table.

The director of wellness was asked to explain how non-caregivers, such as the activity aide who returned the ROC to her room, were able to become familiar with service plan care instructions and directions. According to the wellness director, service plans for every resident was available to all employees.

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.
For Reference: R325.1901	**Definitions.**
	(21) "Service plan" means a written statement prepared by the home in cooperation with a resident and/or the resident's authorized representative or agency responsible for a resident's placement, if any, and that identifies the specific care and maintenance, services, and resident activities appropriate for each individual resident's physical, social, and behavioral needs and well-being and the methods of providing the care and services while taking into account the preferences and competency of the resident.
ANALYSIS:	At time of fall, caregiver #1 attested to ROC's wheelchair brakes being locked. However, caregiver #1 did not attest to the footrests being elevated as required within the ROC's service plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The facility did not follow-up with the ROC regarding possible injuries after she fell.

INVESTIGATION:

According to the written complaint, "On 10/29/22 Mom was discharged from St. Mary's Hospital in Livonia after a second fall at Anthology of Northville. On 10/22/28, X-rays showed compression fractures of L1 and L3 vertebrae. Though local Daughter [name of family member #1] visits Mom nearly every day, both accidents occurred on a day [name of family member #1] was not there… [Name of family member #1] was called 40 minutes after the fall by the Wellness Director, who said Mom was fine. But a short time later Mom complained of neck pain. So [name of family member #1] and her sister [family member #2] called numerous times to ask staff to check Mom and call an ambulance to get her assessed. Staff finally called 911 hours after the fall… Both the June 9 and October 28 falls resulted in fractures. In both cases, daughters had to call 911 (June 9) or insist that Anthology

call 911 (On October 28) … Aide named [name of caregiver] comes in and finds Mom on the floor, on her right side… (at) 4:41p. [Name of director of wellness], Director of Wellness, comes to room and talks to Mom… (at) 4:50p. [Name of director of wellness] calls [name of family member #1] to report Mom was found on the floor, and says Mom is fine, though video shows Mom grimacing as she is lifted off floor… Later: Daughter [name of family member #1] asks Mom via "granny cam" how she is doing; Mom says her neck and back hurt. Mom says she fell head first, as if she dove into a pool. [Name of family member #1] replays video and sees Mom's head hitting the wall. Daughter [name of family member #2] calls reception at Anthology; [employee name] answers. [Name of family member #2] asks to speak to nurse on duty to ask her to check Mom. [Name of family member #2] calls twice. Twice she is sent to voice mail. [Name of family member #2] calls a third time and tells [name of employee] to put her on hold until the duty nurse comes to the phone. [Name of employee] says the agency nurse tells [name of employee] to call [name of director of wellness]. [Names of family members #1 and #2] ask why the duty nurse cannot go confirm that Mom is OK. [Name of employee] comes on the phone. Daughters [names of family members #1 and #2] are both on the line and ask her to call 911 because: (1) Video camera shows a fall; (2) Mom was complaining of neck and back pain; and (3) Her fall involved a head bump, and Mom is on two blood thinners; and (4) There is a lack of trust because the daughters were told June 9 that Mom was fine when she had indeed suffered a shoulder fracture."

When interviewed, family members #1 and #2 stated that they did not believe that the facility completed a thorough assessment after the ROC fell to identify possible injuries. The family members again indicated how concerned they were as they perceived the lack of post-fall follow-up as part of the facility's practice.

During the onsite visit, the director of wellness was asked about what actions the staff were to take after a resident fall. The director of wellness stated that all residents who fell had an assessment to ensure that their range of motion had not become compromised and that no physical injuries were present. All residents who fell were to have "Alert Charting" for 3 days after each fall. The wellness director acknowledged that the facility used a predetermined set of questions for each fall and their post-fall assessment did not deviate from that set, although if there were other factors present, such as faulty equipment, they would make a note of these factors and use them when considering service plan changes.

Review of the ROC's charting notes revealed the following entries for 10/28/2022. At 4:55 pm, "Resident observed on floor on right side of body near wheelchair. Assessed by writer (wellness director) and care staff for bruises. No bruises or abnormalities noted. Daughter [name of family member #1] notified and MD notified…"

At 5:49 pm, "Resident up in chair at dining table having dinner and talking to neighbor… No complaints or s/s (signs and symptoms) of distress at this time.

At 9:38 pm, “Family concerned about resident post incident. Insisted resident should be taken to emergency, 911 contacted, resident sent to [name of local hospital] per family’s request. Transported at 8:40 pm…”

The ROC’s charting notes reflected that she returned to the facility on 10/29/2022 with a “closed compression fracture of L1…”

According to the wellness director, via email message sent on 5/5/2023, “Staff did not notice any facial grimacing when lifting resident off the floor, resident stated she was not in pain… Resident did not inform staff that she was experiencing neck pain, to staff on duty.”

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:	It is not possible to determine when the ROC began to experience pain and if she communicated that to staff.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The facility did not maintain equipment in a safe condition.

INVESTIGATION:

According to the written complaint, “Granny cam replay shows Mom (the ROC) has been left in her wheelchair in a dangerous position, with her legs down…Also, the wheelchair back is tilting forward at less than 90 degrees. Finally, the aide who found her on the floor said the right arm support was missing from the wheelchair and the brake was not on.”

When interviewed, family members #1 and #2 stated that they did not believe that the ROC's wheelchair was properly maintained and that she would have been less likely to have fallen if the wheelchair was upright and had the right arm support.

When the administrator and the wellness director were asked about the ROC's wheelchair and whether it had been set upright, or titled, or had its footrests attached, or was missing the right arm support, the director of wellness reported that the family had contracted the wheelchair directly themselves from the durable medical equipment (DME) vendor. According to the administrator, if there had been any equipment malfunction, the family would need to take it directly back to the DME vendor and that the facility did not get involved at that level.

According to the wellness director, via email message sent on 5/5/2023, "resident's (wheelchair) right arm rest was not missing."

When asked to explain the process that would occur if a facility employee/caregiver were to notice that durable equipment such as a wheelchair were missing components or was malfunctioning, the director of wellness stated that she would instruct the staff member to contact the family and would note it in the resident's health record.

According to the ROC's service plan, "Team members are to ensure wheelchair is in good working order."

APPLICABLE RULE	
R 325.1979	**General maintenance and storage.**
	(1) The building, equipment, and furniture shall be kept clean and in good repair.
ANALYSIS:	There was no evidence that the ROC's wheelchair was in disrepair.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

At the time of the onsite visit, the wellness director was asked to relate the factors that contributed to the ROC's fall on 10/28/2022. The wellness director responded that she did not remember the details well enough to be able to talk about it without

referring to the documentation kept for the ROC. When the wellness director responded via email, she wrote that the fall sustained by the ROC on 10/28/2023 was “due to resident reaching to grab an object from the floor i.e (napkin or ink pen).” However, review of the facility’s document entitled “Fall Assessment Results and Service Plan” revealed that this assessment had been left essentially blank. The only information entered onto the form was the ROC’s diagnoses, allergies, and diet order. There was no mention that the ROC had sustained a fall because she leaned forward to retrieve some object. This determination did not appear on any of the documentation provided by the facility.

According to family members #1 and #2, later, on 10/28/2022, the ROC began to complain of pain. Review of the ROC’s charting notes from 10/28/2022 revealed despite phone calls from family members #1 and #2 to inform the nursing staff that the ROC had told them that she had neck and back pain, the charting notes do not reflect whether the ROC had been asked about pain at the time emergency services had been called.

APPLICABLE RULE	
MCL 333.20175	**Maintaining record for each patient; wrongfully altering or destroying records;**
	Maintaining record for each patient; wrongfully altering or destroying records; noncompliance; fine; licensing and certification records as public records; confidentiality; disclosure; report or notice of disciplinary action; information provided in report; nature and use of certain records, data, and knowledge. (1) A health facility or agency shall keep and maintain a record for each patient including a full and complete record of tests and examinations performed, observations made, treatments provided, and in the case of a hospital, the purpose of hospitalization.
ANALYSIS:	There were omissions in both the ROC’s charting notes and fall assessment document. The documentation provided by the facility did not reflect a “full and complete record of …observations made…” for the ROC.
CONCLUSION:	**VIOLATION ESTABLISHED**

I reviewed the findings of this investigation with the administrator and the wellness director. on 10/17/2023. When asked if there were any comments or concerns with the investigation, the administrator stated that there were none.

IV. RECOMMENDATION

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

10/17/2023

_____

Barbara Zabitz Date
Licensing Staff

Approved By:

10/06/2023

_____

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