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

February 8, 2024

RE: License #: AH820399661
Investigation #: 2023A1022040
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
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enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH820399661
Investigation #:	2023A1022040
Complaint Receipt Date:	07/23/2023
Investigation Initiation Date:	07/24/2023
Report Due Date:	09/22/2023
Licensee Name:	CA Senior Northville Operator, LLC
Licensee Address:	44600 Five Mile Rd Northville, MI 48168
Licensee Telephone #:	(312) 994-1880
Administrator:	Nicole Lumburg
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:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
The Resident of Concern (ROC) did not receive the necessary assistance at bedtime when staff did not help to use the toilet. Some hours later, the ROC tried to self-toilet, fell, and lay on the floor for more than 6 hours before the staff found her there.	Yes
When caregivers did not show up for work, the facility allowed the shift to be short of workers, especially in the memory care (MC) unit.	Yes

III. METHODOLOGY

07/23/2023	Special Investigation Intake 2023A1022040
07/24/2023	Special Investigation Initiated - Telephone Phone call placed to complainant. Left message to call back.
07/27/2023	Contact - Telephone call received. Complainant interviewed by phone.
07/28/2023	APS Referral
07/28/2023	Inspection Completed On-site
08/15/2023	Contact - Document Received Email exchange with administrator.
02/08/2024	Exit Conference

ALLEGATION:

The Resident of Concern (ROC) did not receive the necessary assistance at bedtime, when staff did not help to use the toilet. Some hours later, the ROC tried to self-toilet, fell, and lay on the floor for more than 6 hours before the staff found her there.

INVESTIGATION:

On 07/23/2023, the Bureau of Community and Health Systems (BCHS) received a complaint that read, “On Sun May 21 at 7:20 am the Memory Care Director [name of memory care director] called and said [name of the Resident of Concern (ROC)], my Mom, fell out of bed overnight. [Name of the ROC] has dementia and resides in room 410 in Memory Care. She (memory care director) indicated care staff found her on the floor. She said [name of the ROC] was "checked and in bed" at 4am, and when checked at 6am she was on the floor. So allegedly the fall "happened between 4-6am". The video in [name of the ROC]'s room indicated she fell at 1:20 am and was not found until 7:42am (6+ hours on the floor). [Name of the ROC]’s bedtime is 8:30 pm. At 10:16 pm May 20th staff put [name of the ROC] in bed (without toileting her). At 1:20 am [name of the ROC] awakens and attempts to toilet herself. [Name of the ROC] attempts to stand-up and cannot, so when she tries to lay down she falls off the bed. [Name of the ROC] remains on the floor, writhing around (on her face) with no pants on and no covers, only in a diaper and t-shirt. Finally at 7:42 am a caregiver finds [name of the ROC] & puts her back in bed. [Name of the ROC] has dementia. I (complainant) have video and many emails to Anthology about this event.”

On 07/27/2023, the complainant was interviewed by phone. According to the complainant, the administrator, the authorized representative, the wellness director as well as the memory care director were all aware of her complaints but were never able to find a way to resolve them, as they reoccurred repeatedly. The complainant stated that they were all in agreement after viewing the complainant’s camera footage that the ROC had been put to bed much later than what was planned, without assisting her to the toilet, without dressing the ROC in her preferred night clothes and then went without a staff member checking on her through the night, until staff came in at about 7:42 the next morning. The complainant further described that the ROC was found with bleeding from her head. The complainant moved the ROC out of the facility after this occurrence.

Review of video footage supplied by the complainant revealed an image of the ROC falling or rolling out of bed at 02:21:01 (recorded as Eastern Standard Time as the camera’s settings had not been modified to reflect Eastern Daylight Time) as well as a second image of a caregiver finding the resident lying on the floor at 07:42:59, indicating that the ROC was on the floor for more than 5 hours.

On 07/28/2023, a referral was made to Adult Protective Services.

On 07/28/2023, at the time of the onsite visit, I interviewed the administrator and the director of health and wellness (DHW). Neither individual had clear recollections regarding the ROC and the events of 05/21/2023. Both individuals stated that they needed to refer to their notes, which they provided. The DHW acknowledged that the ROC had fallen out of bed and was found on the floor with an abrasion to either her forehead or her cheek, the DHW was not sure. According the DHW, an incident report (IR) had been completed and sent to their corporate regional nurse for review. The DHW was unable to say whether the IR had resulted in a corrective action plan, but would need to refer to the IR.

According to the IR, dated 05/21/2023 at 7 am, "While entering resident's room staff observed resident on floor between bed and nightstand lying on side. Staff immediately assisted resident off floor and notified nurse. Abrasion on face noted from previous fall on 5/05. Resident to be seen by Hospice nurse this day. Daughter notified…Treatment: no medical treatment…Location of Wound: Abrasion on Top of Head. See Resident Wounds for Charting Details…Immediate Action Taken: Staff assessed resident…" There was no further facility documentation regarding this event.

According to the ROC's service plan, the ROC was independent for transfer and self-ambulation. She was incontinent of "bowel/bladder at times" and wore adult incontinence pull-up briefs. She needed "moderate" assistance for toilet use. The ROC needed extensive assistance for dressing. At night, according to the service plan, her preferred bedtime was noted to be between 9 and 9:30 pm and to be dressed in "clean night clothes of preference at night. She has PJs (pajamas) to sleep in."

On 08/15/2023, via an email exchange with the administrator, the administrator was asked to explain the images and time lapse shown by the complainant's video camera. The administrator responded, "It is the expectation to check our residents on a regular and routine basis as often as the team can throughout the night," but did not explain why caregivers did not find the ROC on the floor until the morning.

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:	The ROC did not receive adequate supervision as evidenced by the length of time she spent lying on the floor by her bed until discovered by a caregiver.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

When caregivers did not show up for work, the facility allowed the shift to be short of workers, especially in the memory care (MC) unit.

INVESTIGATION:

According to the complainant, there were times when there were as many as 23 residents living in the memory care (MC) unit and only 1 caregiver. The complainant alleged that medication technicians did not provide any care and there were many times where she herself pitched in to help with some of the residents. The complainant went on to say that the explanation she was given by the facility management was that an adequate number of caregivers had been scheduled, but that they did not show up to work, so the unit was forced to work short-staffed.

At the time of the onsite visit, when asked about staffing, the administrator stated that the facility did not use an acuity score to determine the staffing. The administrator went on to say that with their current census, they staffed 10 caregivers including medication for every shift, with 3 caregivers plus a medication technician for every shift in the MC unit and the staffing would have been the same in May. According to the administrator, at the time of the onsite visit, there were 22 residents in the MC unit. Review of staffing from 05/07/2023 through 05/13/2023 revealed that there were only 2 caregivers plus the medication technician scheduled. Review of employee “punch-in” times revealed that there was only 1 caregiver scheduled on the day shift of 05/07/2023 who called-off and was not replaced. When the administrator was asked to explain why the staffing was not as she had described at the time of the onsite visit, she stated (via email exchange), “The week of 05/07 is when we transitioned to schedule (3) caregivers and a Med Tech to MC during 1st and 2nd shift. Between the hours of 10pm and 6am (2) caregivers and (1) med tech are scheduled to MC.” The administrator did not explain why there were only 2 caregivers scheduled for the day and the afternoon shifts. For 05/07/2023, the administrator provided an assignment sheet that directed the medication technician to “assist with care” along with her duties with medication administration. For that Sunday, on the day shift, there was only 1 caregiver and 1 medication technician.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(5) The home shall have adequate and sufficient staff on duty at all times who are awake, fully dressed, and capable of providing for resident needs consistent with the resident service plans.
ANALYSIS:	The facility did not schedule the number of caregivers they stated were needed to provide a standard level of care.
CONCLUSION:	**VIOLATION ESTABLISHED**

I reviewed the findings of this investigation with the administrator on 02/08/2024. 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.

02/08/2024

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Barbara Zabitz Date
Licensing Staff

Approved By:

01/17/2024

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