GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

February 29, 2024

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

RE: License #: AH630402476
Investigation #: 2024A0784025
Anthology of Farmington Hills

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

Please review the enclosed documentation for accuracy and contact me with any questions. If I am not available, and you need to speak to someone immediately, please contact the local office at (517) 284-9730.

Sincerely,

Aaron L Clum

Aaron Clum, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 230-2778

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630402476
Investigation #:	2024A0784025
Complaint Receipt Date:	01/24/2024
Investigation Initiation Date:	01/25/2024
Report Due Date:	03/24/2024
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:	Dolanda Scott
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:	09/30/2023
Expiration Date:	09/29/2024
Capacity:	120
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A was not charged according to her contract	No
Resident A's service plan was not updated timely for her care	Yes
Resident A was mistreated by staff	No
Additional Findings	No

III. METHODOLOGY

01/24/2024	Special Investigation Intake 2024A0784025
01/25/2024	Special Investigation Initiated - On Site
01/25/2024	Inspection Completed On-site
02/29/2024	Exit - Email Report Sent

ALLEGATION:

Resident A was not charged according to her contract

INVESTIGATION:

On 1/24/2023, the department received this complaint.

According to the complaint, the facility was notified, in writing, on 10/09/2023 that Resident A would be voluntarily discharging from the facility. Resident A was not living at the facility from 10/21/2023 to 11/09/2023 and was still charged for those dates. Additionally, the complaint indicated the facility is responsible for reimbursing the initial $3000.00 community fee, paid upon moving into the facility, due to alleged improper care of Resident A.

On 1/25/2024, I interviewed administrator Dolanda Scott at the facility. Ms. Scott stated Resident A was charged according to her contract. Ms. Scott stated the facility was notified on 10/09/2023 that Resident A would be discharging from the facility. Ms. Scott stated Resident A was charged until 11/09/2023 because the contract specifies that the facility must receive a one month notice of discharge, so

she was charged according to the specifications of the contract. Ms. Scott stated the $3000.00 community fee is not refundable and is also specified in the contract.

I reviewed a letter signed from Resident A's authorized representative, dated 10/09/2023, provided by Ms. Scott. The letter indicates the intention to voluntarily move Resident A from the facility.

I reviewed Resident A's *RESIDENCY AGREEMENT*, provided by Ms. Scott. Under a section titled *TERM*, the agreement read, in part, "This agreement shall automatically renew for additional one-month terms, unless any party to the agreement serves (30) thirty days advance written notice of termination to all parties". Under a section titled Community Fee, the agreement read, "Prior to or at the time of move-in, you shall be responsible to pay a one-time non-refundable community fee in the amount of $3000.00. The Community Fee is not a security deposit as that term is defined under state law and will not be refunded for any reason".

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(4) If there is a change in a term or condition in the written resident admission contract, then the home or home's designee shall review the change with the resident and the resident's authorized representative, if any.
ANALYSIS:	The complaint alleged Resident A was not charged according to her contract. The investigation revealed insufficient evidence to support the allegation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A's service plan was not updated timely for her care

INVESTIGATION:

According to the complaint, when Resident A first moved to the facility, she was able to walk and transfer on her own. After a fall on approximately 8/11/2023, Resident A was no longer able to walk or transfer on her own and was repeatedly falling, however, her service plan was not updated to reflect her additional care needs.

When interviewed, Ms. Scott stated Resident A was assessed by Associate 1 for necessary changes to the service plan. Ms. Scott stated Associate 1 had just started working with the facility around the time of Resident A's fall and would need to confirm the updates for the service plan. Ms. Scott stated Resident A did require increased care after the fall and was a high fall risk person.

On 1/25/2024, I interviewed Associate 1 at the facility. Associate 1 stated she started working with the facility on 8/16/2023. Associate 1 stated she did evaluate Resident A shortly after starting work with the facility. Associate 1 stated Resident A was high risk for falls and had low safety awareness. Associate 1 stated that after Resident A's fall, she was taken to the hospital and was discovered with injuries as described in the complaint. Associate 1 stated the service plan was not immediately changed as there were ongoing discussions with Resident A's authorized rep about the care she needed and disagreements about the level of care. Associate 1 stated that when she was finally able to update Resident A's service plan, the plan was appropriately updated to include the level of care needed. Associate 1 stated Resident A was a person requiring "full assistance" with mobility such as transferring and ambulating.

I reviewed Resident A's service plan, provided by Ms. Scott. The plan read consistently with statements provided by Associate 1 describing Resident A as requiring "total support" from staff for *Transferring*, *Ambulation* and activities of daily living (ADLs) such as *Bathing*. Review of the plan revealed Associate 1 assessed Resident A last on "9/15/2023" with the last modifications to the plan completed on 10/01/2023.

I reviewed facility incident tracking documentation for Resident A, provided by Ms. Scott, which confirmed Resident A's fall on 8/11/2024.

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(5) A home shall update each resident's service plan at least annually or if there is a significant change in the resident's care needs. Changes shall be communicated to the resident and his or her authorized representative, if any.
For Reference: R 325.1901	**Definitions**
	(t) "Service plan" means a written statement prepared by the home in cooperation with a resident, the resident's authorized representative, or the agency responsible for a resident's placement, if any, that identifies the specific care and maintenance, services, and resident activities appropriate for the 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:	The complaint alleged Resident A had a fall on 8/11/2024 and that the facility did not update the plan in a timely manner specific to the additional care Resident A needed. While the investigation revealed the facility was actively working to assess Resident A's needs in order to implement necessary changes, review of the plan indicated an assessment date of 9/15/2023. Additionally, while the assessment date was listed as 9/15/2023, the date listed on the plan for updates was not until 10/01/2023. Based on the findings, the allegation is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A was mistreated by staff

INVESTIGATION:

According to the complaint, Resident A's fall on 8/11/2023 was due to "hiding" her walker. Additionally, Resident A reported that she was getting bruised from staff being too rough with her. On 9/27/2023, Resident A was evaluated by a nurse, unaffiliated with the facility, at the request of Resident A's authorized representative. The nurse reportedly arrived early in the afternoon to the facility on the day of the evaluation and heard several staff, who were helping assist Resident A say, "hurry up, a nurse is coming" and felt this was indicative of "rough handling".

When interviewed, Ms. Scott stated she did receive a report that Resident A believed someone hide her walker prior to her fall on 8/11/2023. Ms. Scott stated she did follow up with staff working the day of the fall who denied such actions. Ms. Scott stated she asked Resident A about the complaint and that while Resident A reported feeling that someone moved her walker, she would not provide a name of who she thought did it or why someone would do it. Ms. Scott stated she did not have any reason to believe any of her staff would do such a thing. Ms. Scott confirmed Resident A was evaluated by a nurse 9/27/2023. Ms. Scott stated she did not know who the nurse was specifically, but that she believed she was from another facility there to evaluate Resident A for placement. Ms. Scott stated the nurse did not provide her name or what facility she was from but was there at the request of Resident A's authorized representative. Ms. Scott stated she was not aware of any complaints of bruising on Resident A. Ms. Scott stated Resident A did not complain to her of any poor treatment from staff and that the assessing nurse did not report anything to her. Ms. Scott stated the visiting nurse only reported to her that she felt Resident A required a high level of care. Ms. Scott stated Associate 1 was also

present on 9/27/2023. Ms. Scott stated Resident A was a bigger person and that it would be possible Resident A obtained some light bruising from time to time during staffs attempt to assist her. Ms. Scott stated she did not have any reason to believe staff would harm Resident A on purpose. Ms. Scott stated Resident A did receive regular skin assessments and she was not aware of Resident A having any bruising at that time.

When interviewed, Associate 1 confirmed her presence at the facility on 9/27/2023 and provided statements consistent with those of Ms. Scott. Associate 1 stated she also spoke directly to the visiting nurse and that the nurse made a statement about Resident A's authorized representative that she felt the authorized representative was "crazy" which she stated was an unusual thing for someone to say in that circumstance.

I reviewed a document attributed to Resident A titled Skin Integrity Monitoring Form, provided by Ms. Scott. The form was dated 9/25/2023 and indicated no bruising or discoloration to Resident A's body. There was a handwritten note on the form which read "arm in cast" as Resident A had a cast related to her previous fall.

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents**
	(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 or a physician's assistant to whom the physician has delegated the performance of medical care services 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 or physician's assistant. In case of a chemical restraint, a physician shall be consulted within 24 hours after the commencement of the chemical restraint.
ANALYSIS:	The complaint alleged mistreatment of Resident A by staff. The investigation did not reveal sufficient evidence to support the allegation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, it is recommended that the status of the license remain unchanged.

2/27/2024

Aaron Clum — Date
Licensing Staff

Approved By:

02/29/2024

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