GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 25, 2026

Michele Locricchio
Fairmont Senior Living of Northville
15870 N Haggerty Rd
Plymouth, MI 48170

RE: License #: AH820408530
Investigation #: 2026A0784032
Fairmont Senior Living of Northville

Dear Michele Locricchio:

Attached is the Special Investigation Report for the above-mentioned 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) 335-5985.

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

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

I. IDENTIFYING INFORMATION

License #:	AH820408530
Investigation #:	2026A0784032
Complaint Receipt Date:	05/07/2026
Investigation Initiation Date:	05/07/2026
Report Due Date:	07/06/2026
Licensee Name:	Northville Operations LLC
Licensee Address:	15870 N. Haggerty Road Plymouth, MI 48170
Administrator/Authorized Representative:	Michele Locricchio
Name of Facility:	Fairmont Senior Living of Northville
Facility Address:	15870 N Haggerty Rd Plymouth, MI 48170
Facility Telephone #:	(734) 420-7917
Original Issuance Date:	06/18/2021
License Status:	REGULAR
Effective Date:	08/01/2025
Expiration Date:	07/31/2026
Capacity:	120
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Lack of adequate care and protection for Resident A	Yes
Additional Findings	No

III. METHODOLOGY

05/07/2026	Special Investigation Intake 2026A0784032
05/07/2026	Special Investigation Initiated - Telephone Contacted attempted with complainant. Message left requesting a return call
05/07/2026	Contact - Document Sent Email sent to complainant
05/07/2026	Contact - Document Received Email from complainant with attached supporting documentation
05/08/2026	Inspection Completed On-site
06/25/2026	Exit - Email Report sent

ALLEGATION:

Lack of adequate care and protection for Resident A

INVESTIGATION:

On 5/07/2026, the department received this online complaint.

According to the complaint, "On 5/7/26 at approximately 0536 (5:36am), the Northville Township Fire Department was dispatched to this location to evaluate a resident (Resident A) who had fallen. Upon entry to the facility the crew observed 3 staff members near the front door, one gathering patient paperwork and 2 others sitting on their electronic devices. One staff member asked the responding crew, before they had even made patient contact, if they could obtain the patient's vital signs from the crew on the way out, indicating the patient had not been assessed by staff prior to calling 911. The crew then proceeded to the memory care area and found another staff member sitting on their electronic device. Upon reaching the patient's room, the crew found him uncovered on the floor, covered in blood that had

obviously been drying for hours, as scabbing and coagulation were noted. The area around the patient was covered in blood, including the floor, bed, and nightstand. No sheets or blankets were found on the patient's bed or in the room. The patient had a head laceration that had not been addressed by facility staff, and also had multiple skin tears on his body, the worst appearing on his knees. The patient was rocking back and forth on the floor, complaining that he was cold. After assessing the patient and dressing his wounds, he was prepared for transport. On the way to the ambulance, the staff again asked for his vital signs, which the crew did not provide to them". Additionally, the complaint indicated that EMS staff believed that based on the condition of the blood and that Resident A was cold, he likely sat for many hours on the floor and that upon finding him, the staff did absolutely nothing to assess him, treat his injuries, or even protect him from further heat loss.

On 5/07/2026, I interviewed complainant by telephone. Complainant stated the information provided in the complaint was reported by the emergency service workers who witnessed the events. Complainant stated a report would be made available for review.

I reviewed a report titled *Patient Care Record* for the incident involving Resident A provided by Complainant. The report read consistently with statements provided in the complaint.

On 5/08/2026, I interviewed staff 1 at the facility. Staff 1 stated confirmed that on the morning of 5/7/2026, Resident A was observed to have fallen and hit his head causing him to bleed as described in the complaint. Staff 1 stated she was not present during this time, but that staff who attended Resident A that morning provided written statements regarding their actions. Staff 1 stated staff 2 reported that on the morning of the incident, at approximately 5:20am, staff 3 had retrieved her for assistance reporting she observed Resident A laying on the floor bleeding after a fall. Staff 1 stated staff 2 reported she attempted to contact Resident A's hospice service and after waiting several minutes on hold with no answer, contacted administrator Michele Locricchio who instructed her to call 911. Staff 1 stated staff 2 reported contacting 911 immediately after speaking with administrator. Staff 1 stated staff 2 reported she then left the room to obtain medication list and contact information to give to emergency medical services (EMS). Staff 1 stated staff 2 reported that staff 3 and 4 were in the room with Resident A at that time. Staff 1 stated staff 2 confirmed both staff 3 and 4 had left the room, apparently to attend to other residents, after staff 2 had left, leaving Resident A alone without having covered him up or taken his vitals. Staff 1 stated staff 3 should not have left Resident A alone and should have taken his vitals before EMS arrived. Staff 1 stated staff 3 reported Resident A was not in his room for several hours alone having reported she last checked on him at approximately 4:12am during regular rounding well checks.

I reviewed a written statement from staff 2, provided by staff 1. The statement read consistently with statements provided by staff 1.

I reviewed a written statement from staff 3, provided by staff 1. The statement provided by staff 3 read consistently with that of staff 2's statements regarding the initial timeline of events when Resident A was found.

I reviewed a written statement from staff 4. The statement from staff 4 read consistently with statements provided by staff 1, 2 and 3. Staff 4's statement provided more detail regarding Resident A being left alone. The statement confirmed both staff 3 and 4, left Resident A alone and that when EMS arrived, they found Resident A still alone. The statement indicated an apparent disagreement between staff 3 and 4 as to who was supposed to stay with Resident A while both reportedly left to attend to other residents.

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.
ANALYSIS:	Based on reporting from staff, there is sufficient evidence to support the claim that staff did not provide adequate care for Resident A's safety and protection. After a fall in which Resident A suffered injuries causing him to significant bleeding, staff left him alone until EMS arrived to provide him with assistance.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Aaron L Clum 6/23/2026

Aaron Clum Date
Licensing Staff

Approved By:

Andrea L Moore 06/25/2026

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