GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 20, 2022

Marilyn Jenkins
Lakeside Manor Inc
8790 Arlington
White Lake, MI 48386

RE: License #: AL630086778
Investigation #: 2022A0602013
Lakeside Manor Inc

Dear Ms. Jenkins:

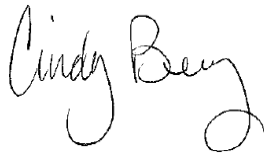
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 responsible party 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 (248) 975-5053.

Sincerely,



Cindy Berry, Licensing Consultant
Bureau of Community and Health Systems
3026 West Grand Blvd
Cadillac Place, Ste 9-100
Detroit, MI 48202
(248) 860-4475

enclosure

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

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AL630086778 |
| | |
| **Investigation #:** | 2022A0602013 |
| | |
| **Complaint Receipt Date:** | 01/10/2022 |
| | |
| **Investigation Initiation Date:** | 01/10/2022 |
| | |
| **Report Due Date:** | 03/11/2022 |
| | |
| **Licensee Name:** | Lakeside Manor Inc |
| | |
| **Licensee Address:** | 8790 Arlington<br>White Lake, MI 48386 |
| | |
| **Licensee Telephone #:** | (248) 666-9010 |
| | |
| **Administrator:** | Marilyn Jenkins |
| | |
| **Licensee Designee:** | Marilyn Jenkins |
| | |
| **Name of Facility:** | Lakeside Manor Inc |
| | |
| **Facility Address:** | 8790 Arlington<br>White Lake, MI 48386 |
| | |
| **Facility Telephone #:** | (248) 666-9010 |
| | |
| **Original Issuance Date:** | 11/13/2000 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 07/07/2021 |
| | |
| **Expiration Date:** | 07/06/2023 |
| | |
| **Capacity:** | 20 |
| | |
| **Program Type:** | MENTALLY ILL<br>AGED |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| **On 12/30/2021, Resident F arrived at the emergency room with hypothermia of an unknown cause.** | No |
| Additional Findings | Yes |

## III. METHODOLOGY

| | |
|---|---|
| 01/10/2022 | Special Investigation Intake<br>2022A0602013 |
| 01/10/2022 | APS Referral<br>Adult Protective Services (APS) referral received. |
| 01/10/2022 | Special Investigation Initiated - Telephone<br>Call made to APS; Marcie Fincher assigned worker. |
| 01/21/2022 | Inspection Completed On-site<br>Interviewed the home manager, Nancy Huntington; reviewed Resident F's file. |
| 01/27/2022 | Contact – Telephone call made<br>Spoke with APS worker, Ms. Fincher. |
| 02/01/2022 | Contact – Telephone call made<br>Message left for Resident F's guardian. |
| 02/01/2022 | Contact – Document received<br>Email received from Ms. Fincher. |
| 02/15/2022 | Contact – Telephone call received<br>Spoke with the home manager, Nancy Huntington. |
| 03/10/2022 | Contact – Telephone call made<br>Message left for Resident F's guardian. |
| 04/07/2022 | Exit conference<br>Message left for licensee designee, Marilyn Jenkins |
| 04/08/2022 | Contact – Telephone call received<br>Spoke with the licensee designee Marilyn Jenkins. |

| | |
|---|---|
| 04/19/2022 | Contact – Telephone call made<br>Spoke with Resident F's guardian |

**ALLEGATION:**

**On 12/30/2021, Resident F arrived at the emergency room with hypothermia of an unknown cause.**

**INVESTIGATION:**

On 1/10/2022, a complaint was received and assigned for investigation alleging that on 12/30/2021 Resident F arrived at the emergency room with hypothermia of an unknown cause.

On 1/21/2022, I conducted an unannounced on-site investigation at which time I interviewed the home manager, Nancy Huntington, and reviewed documents from Resident F's file. Ms. Huntington stated 12/28/2021 was the last day she worked before Resident F was transported to the hospital and he had no issues. On 12/30/2021, staff member Andrew Knowles worked the third shift between the hours of 11 pm and 7 am. She received a call from Mr. Knowles around 6:38 am informing her that Resident F had fallen three times during the night. Mr. Knowles was able to assist him up from the floor twice but was unable to assist him up after the third fall. Ms. Huntington informed Mr. Knowles that she was almost to the home. When she arrived, she was unable to get Resident F up from the floor and 911 was called around 7:10 am. The fire department arrived first (exact time unknown) and were able to get Resident F up from the floor and into a chair. Emergency medical services (EMS) arrived at the home around 7:20 am and Resident F was transported to McLaren Oakland Hospital around 7:30 am. Resident F was admitted to the hospital and has not returned to the home. According to Ms. Huntington since being hospitalized, Resident F was moved to the intensive care unit (ICU), had a peg tube put in place and started having seizures. Ms. Huntington stated Resident F had not been outside prior to being hospitalized and she had no explanation for why he was diagnosed with hypothermia when he arrived at the emergency room.

On 1/21/2022, I received and reviewed Resident F's health care appraisal dated 8/21/2021, and his list of medications. According to the health care appraisal, Resident F was diagnosed with hypoglycemia, a history of weakness and dizziness. Resident F was fully ambulatory but with an unsteady gait. The following medications were prescribed to Resident F:

- Tamsulosin HCL 0.4 mg Cap – 2 caps by mouth daily after dinner
- Trazodone 50 mg Tab – 1 tab by mouth at bedtime
- Valproic Acid 250 mg/5 ML – 10 mg by mouth twice daily
- Zioptan 0.0015% eye drop – Instill 1 drop in each eye in the evening
- Atorvastatin 80 mg Tab – ½ tab by mouth in the evening

- Brimonidine 0.2% eye drop – Instill 1 drop in each eye three times daily
- Dorzolamide-Timolol 2% - Instill 1 drop in each eye twice daily
- Fluphenazine 2.5 mg Tab – 1 tab by mouth twice daily
- Multivitamin Tab – 1 tab by mouth daily

On 1/27/2022, I spoke with the assigned APS worker, Marcie Fincher by telephone. Ms. Fincher stated Resident F passed away on 1/26/2022 but she did not have a cause of death.

On 2/01/2022, Ms. Fincher provided progress notes from McLaren Oakland Hospital dated 12/31/2021-1/11/2022. According to the notes, Resident F arrived at the emergency department (ED) with a chief complaint of increased falls; having fallen multiple times on 12/30/2021 while at the group home. Resident F's mentation was documented as nonverbal at baseline. While in the ED, Resident F's rectal temperature was found to be 80 degrees Fahrenheit. Resident F was given 1 liter of normal saline along with warm saline and a Bair Hugger (a forced air warming system designed to prevent hypothermia and keep patients at a normal core body temperature) was utilized. Resident F was found not to be protecting his airway and was intubated. During the timeframe of 12/31/2021-1/11/2022, Resident F remained intubated, began having seizures, and had a peg tube and tracheostomy performed.

On 2/01/2022, I also received and reviewed (from Ms. Fincher) notes from the White Lake Fire Department that documented Resident F as being responsive, thankful to be off the floor and was not cold to touch.

On 2/15/2022, I spoke with Ms. Huntington by telephone. Ms. Huntington said she finds it hard to believe that this is being investigated. Resident F was talking when he was transported to the hospital, and she cannot believe his body temperature was low.

On 4/19/2022 I spoke with Resident F's guardian, Marlena Geha by telephone. Ms. Geha stated she was appointed as Resident F's guardian in 1999 and he has lived at Lakeside Manor the entire time. She said she has other residents who reside at Lakeside Manor and has never had an issue with the care they receive. She visits them once every week and she has never received any complaints. The day Resident F fell, Ms. Huntington was in contact with her and kept her informed. Once Resident F arrived at the hospital, she received a call informing her that he was there. The staff never mentioned to her that Resident F was admitted with hypothermia and had a body temperature of 80 degrees. However, it was mentioned later in the documents she received from the hospital. Ms. Geha went on to state that if Resident F had a body temperature of 80 degrees when he arrived at the hospital, he more than likely would not have been verbal. She believes the body temperature reading was inaccurate because his vitals were normal when taken by EMS before being transported to the hospital. Ms. Geha received a copy of Resident F's death certificate, and his cause of death is listed as pneumonia with septic shock.

| APPLICABLE RULE | |
|---|---|
| **R 400.15305** | **Resident protection.** |
| | (3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act. |
| **ANALYSIS:** | Based on the information obtained during the investigation, I determined there is insufficient information to determine that Resident F suffered from hypothermia because of staff negligence.<br><br>According to Ms. Huntington, Ms. Jenkins, and Ms. Geha, Resident F was alert and talking when EMS arrived at the home. If he had a body temperature of 80 degrees, it would have been difficult for him to be alert and communicating so well.<br><br>The White Lake Fire Department documented that Resident F was not cold to touch, was responsive and thankful to be off the floor while at the home. |
| **CONCLUSION:** | VIOLATION NOT ESTABLISHED |

**ADDITIONAL FINDINGS**

**INVESTIGATION:**

On 1/21/2022, I conducted an unannounced on-site investigation at which time I interviewed the home manager, Nancy Huntington. Ms. Huntington stated on 12/30/2021 she received a call from Mr. Knowles around 6:38 am informing her that Resident F had fallen three times during the night. Mr. Knowles was able to assist him up from the floor twice but was unable to assist him up after the third fall. Ms. Huntington informed Mr. Knowles that she was enroute to the home and was almost there. When she arrived, she was unable to get Resident F up from the floor and 911 was called around 7:10 am. The fire department arrived first (exact time unknown) and were able to get Resident F up from the floor and into a chair. Emergency medical services (EMS) arrived at the home around 7:20 am and Resident F was transported to McLaren Oakland Hospital around 7:30 am.

On 2/01/2022, I also received and reviewed (from Ms. Fincher) notes from the White Lake Fire Department. According to the notes, Fire Sergeant Steve reported that on 12/30/2021 the call came into the fire station as a fall and the fire department was dispatched to the group home at 7:22 am and arrived at 7:28 am. They used a lifting tarp to get Resident F up from the floor and into a chair. He was responsive and thankful to be off the floor. Star EMS was dispatched to the home at 7:24 am and

arrived at 7:44 am. There was a 20-minute response time as they were coming from Commerce Township. Staff at the home (name unknown) informed the fire department that Resident F had been on the floor for 45 minutes before they called for assistance. Resident F was not cold to touch and was responsive while at the home.

On 4/07/2022, I left a message for the licensee designee, Marilyn Jenkins requesting a return call to conduct an exit conference.

On 4/08/2022, I conducted an exit conference with the licensee designee, Marilyn Jenkins by telephone. I informed Ms. Jenkins of the investigative findings and recommendation documented in this report. Ms. Jenkins stated Resident F resided in her home for almost 25 years and he was like family. He was a very large man weighing around 200 pounds and 6'4" tall. The day he fell he remained alert and oriented the entire time. Staff gave him a pillow and a blanket while he was on the floor. When EMS arrived, they took his vitals, and they were all normal. He was talking and answering questions. According to Ms. Jenkins, Resident F had not been outside, so it is unclear to her why the hospital stated he was admitted with a body temperature of 80 degrees. Ms. Jenkins further stated that she feels as if her staff did everything they should have done as it did not present as being an emergency when Resident F fell. 911 was called when two staff were unable to get Resident F up from the floor. However, she agreed to submit a corrective action plan upon receipt of the report and retrain staff.

| **APPLICABLE RULE** | |
|---|---|
| **R 400.15310** | **Resident health care.** |
| | (4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately. |
| **ANALYSIS:** | Based on the information obtained during the investigation, I determined that on 12/30/2021 staff member, Andrew Knowles did not immediately obtain the needed care for Resident F.<br><br>According to Ms. Huntington, on 12/30/2021 around 6:38 am she received a call from Mr. Knowles informing her that Resident F had fallen, and he could not get him up from the floor. When Ms. Huntington arrived (exact time unknown) she attempted to assist Resident F up from the floor but was unsuccessful. 911 was called. The fire department arrived around 7:10 am, EMS arrived around 7:20 am and Resident F was transported to the hospital around 7:30 am.<br><br>According to Fire Sergeant Steve's notes, the fire department received the call at 7:22 am, arrived at the home at 7:28 am and used a lifting tarp to get Resident F up from the floor. Therefore, |

| | |
|---|---|
| | if Ms. Huntington received the call from Mr. Knowles around 6:38 am and the fire department was not contacted until 7:22 am, Resident F was on the floor for 44 minutes before receiving care. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

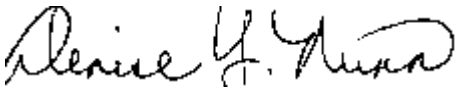
## IV. RECOMMENDATION

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

04/19/2022

Cindy Berry Date
Licensing Consultant

Approved By:



04/20/2022

Denise Y. Nunn Date
Area Manager