GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 22, 2023

Erica Thrash-Sall
McFarlan Home
700 E. Kearsley St.
Flint, MI 48503

RE: License #: AH250356639
Investigation #: 2023A0784023
McFarlan Home

Dear Ms. Thrash-Sall:

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.

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 #:	AH250356639
Investigation #:	2023A0784023
Complaint Receipt Date:	01/09/2023
Investigation Initiation Date:	01/10/2023
Report Due Date:	03/10/2023
Licensee Name:	McFarlan Kearsley Residence, LLC
Licensee Address:	700 Kearsley St. Flint, MI 48503
Licensee Telephone #:	(810) 252-8684
Administrator:	Kelly Price
Authorized Representative:	Erica Thrash-Sall
Name of Facility:	McFarlan Home
Facility Address:	700 E. Kearsley St. Flint, MI 48503
Facility Telephone #:	(810) 235-3077
Original Issuance Date:	05/30/2014
License Status:	REGULAR
Effective Date:	11/30/2022
Expiration Date:	11/29/2023
Capacity:	29
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Inadequate supervision and protection of Resident A	Yes
Additional Findings	Yes

III. METHODOLOGY

01/09/2023	Special Investigation Intake 2023A0784023
01/10/2023	Special Investigation Initiated - On Site
01/10/2023	Inspection Completed On-site
02/16/2023	Contact - Telephone call made Interview with Ms. Price
02/16/2023	Contact - Telephone call made Attempted contact with Associate 1. Message left
02/16/2023	Exit Conference – Telephone Conducted with authorized representative Erica Thrash-Sall

ALLEGATION:

Inadequate supervision and protection of Resident A

INVESTIGATION:

On 1/06/2023, the department received an incident report from the facility indicating that on 12/31/2022 at 7pm, "[Resident A] was escorted to her unit after dinner by [Associate 1]. [Resident A] collapsed in front of her unit in the hallway on the second floor. At the time she collapsed, it is believed that [Resident A] was not using her oxygen. There is an ongoing investigation to determine when her oxygen was in use". Additionally, the report indicated that 911 was called and that first responders were unsuccessful in performing life saving measures.

On 1/10/2023, I interviewed administrator Kelly Price at the facility. Ms. Price stated Resident A was prescribed a portable oxygen tank which she was supposed to be using at all times. Ms. Price stated she was on leave when in the incident happened, but it that it was her understanding that Associate 1 was with Resident A when she

collapsed at her door coming back from dinner. During the onsite inspection, I had Ms. Price escort me from the dining area on the first floor to the elevator, then to Resident A's room, the path she stated Resident A and Associate 1 took on the date of the incident. It should be noted that it took approximately 64 steps from Resident A's assigned table to her room. Ms. Price stated Associate 1 had worked at the facility for several months and would have been aware of Resident A's need to have her oxygen with her while ambulating.

On 2/16/2023, I interviewed Ms. Price by telephone. Ms. Price stated she and authorized representative Erica Thrash-Sall did follow up with Associate 1 regarding why Resident A did not have her portable oxygen with her at the time of the incident when being escorted by Associate 1. Ms. Price stated Associate 1 was unable to provide an explanation as to why this happened.

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: R 325.1901	**Definitions**
	(16) "Protection" means the continual responsibility of the home to take reasonable action to ensure the health, safety, and well-being of a resident as indicated in the resident's service plan, including protection from physical harm, humiliation, intimidation, and social, moral, financial, and personal exploitation while on the premises, while under the supervision of the home or an agent or employee of the home, or when the resident's service plan states that the resident needs continuous supervision.

ANALYSIS:	The department received an incident report from the facility indicating that on 12/31/2022, Resident A was being escorted back to her room from dinner, without her necessary oxygen, and collapse in front of her room. The report further indicated EMS was contacted and arrived to attend to Resident A, however they were unable to revive her, and she passed away. The investigation confirmed Associate 1 escorted Resident A to her room, approximately 64 steps from Resident A's assigned seat in the dining area, without ensuring she had her oxygen. Based on the findings, it is reasonable to conclude that Associate 1 did not adequately protect and supervise Resident A in that while she was aware of Resident A's need for her oxygen while ambulating, Associate 1 did not ensure Resident A had it with her when escorting her back from dinner.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

I reviewed Resident A's service plan, provided by Ms. Price. Under a section titled *Transfer*, the plan indicates Resident A transferred "independently". Under a section titled *Mobility*, the plan indicated Resident A was "independent" with the use of a "walker". Under a section titled Respiratory *Therapy & Oxygen,* the plan indicated "none".

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**
	(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:	Under a section titled *Transfer*, the plan indicates Resident A transferred “independently”. Under a section titled *Mobility*, the plan indicated Resident A was “independent” with the use of a “walker”. Under a section titled Respiratory *Therapy & Oxygen,* the plan indicated “none”.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

Review of the incident report email submission revealed the facility reported this incident on 1/06/2023.

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, accidents, elopement.**
	(3) The home shall report an incident/accident to the department within 48 hours of the occurrence. The incident or accident shall be immediately reported verbally or in writing to the resident's authorized representative, if any, and the resident's physician.
For Reference: R 325.1901	**Definitions**
	(17) "Reportable incident/accident" means an intentional or unintentional event in which a resident suffers harm or is at risk of more than minimal harm, such as, but not limited to, abuse, neglect, exploitation, or unnatural death.
ANALYSIS:	The incident involving Resident A was revealed to have happened on 12/31/2022, however the department did not receive the incident report until 1/06/2023. Based on the findings the facility is not in compliance with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

2/16/2023

Aaron Clum — Date
Licensing Staff

Approved By:

02/21/2023

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