GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

Kahlia Harper
McFarlan Home
700 E. Kearsley St.
Flint, MI 48503

January 30, 2024

RE: License #: AH250356639
Investigation #: 2024A1011006
McFarlan Home

Dear Ms. Harper:

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 licensee's authorized representative 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 (877) 458-2757.

Sincerely,

Andrea Krausmann, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(586) 256-1632

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH250356639
Investigation #:	2024A1011006
Complaint Receipt Date:	12/21/2023
Investigation Initiation Date:	01/02/2024
Report Due Date:	02/20/2024
Licensee Name:	McFarlan Kearsley Residence, LLC
Licensee Address:	700 Kearsley St. Flint, MI 48503
Licensee Telephone #:	(810) 252-8684
Administrator:	Christie Moyer
Authorized Representative:	Kahlia Harper
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:	11/30/2023
Expiration Date:	11/29/2024
Capacity:	29
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was not protected from drinking alcohol and consequently, she suffered falls on Saturday and Sunday.	Yes
Additional Findings	Yes

III. METHODOLOGY

12/21/2023	Special Investigation Intake 2024A1011006
01/02/2024	Special Investigation Initiated - Telephone Received complaint upon return to office on 01/02/2024. Called complainant for clarification of allegations. Left voice mail message requesting call back.
01/03/2024	Contact - Telephone call received Interviewed complainant.
01/03/2024	Contact - Telephone call made Called facility - no answer. Left voice mail for licensee's authorized representative Erica Thrash-Sall requesting call back.
01/03/2024	Contact - Telephone call made Called facility again and spoke with Christie Moyer Administrative Assistant. She will have Executive Director Kahlia Harper call me back.
01/03/2024	Contact - Telephone call received Former authorized representative Erica Thrash-Sall called to report that she left her position in July 2023.
01/03/2024	Contact - Telephone call received Kahlia Harper returned my call and a brief interview was conducted because it was end of workday and she is not in her office. Will follow up in the morning.
01/03/2024	Contact - Document Sent Sent my contact information to K. Harper for her to submit various paperwork in morning.
01/01/2024	Contact - Document Received

	Documentation appointing K. Harper as the licensee's authorized representative received.
01/04/2024	Contact - Document Received Resident's service plan and POA papers received from Kahlia Harper via email. I then requested additional documentation.
01/04/2024	Contact - Telephone call made Interviewed K. Harper.
01/04/2024	Contact - Document Received Additional documentation received including a physician's order, incident reports and staff notes. Ms. Harper also wrote on her email, "Good morning Please see attached. I spoke with staff and they were under the impression the wine was removed at the end of December. However, as of yesterday evening, there was still wine in the room. I do not know if this is the original wine I observed or if more was brought in. Thanks, Kahlia Harper Executive Director, McFarlan Villages"
01/10/2024	Contact - Document Received Documentation appointing C. Moyer as the facility's administrator.
01/30/2024	APS Referral Provided allegations to adult protective services (APS) Centralized Intake Unit MDDHS-CPS-CIGROUP@michigan.gov via emailed referral form.
01/30/2024	Exit Conference – Conducted with licensee's authorized representative Kahlia Harper via telephone.

ALLEGATION:

Resident A was not protected from drinking alcohol and consequently, she suffered falls on Saturday and Sunday.

INVESTIGATION:

On 01/02/2024, I interviewed the complainant by telephone. The complainant said that Resident A has dementia. She has been provided wine by her son, although Resident A's physician advised she drink no alcohol because of the medications she is prescribed. Resident A had wine from her family member (FM1) and reportedly became intoxicated. Consequently, she had falls on 12/16 and 12/17/23.

On 01/03 and 01/04/2024, I interviewed the licensee's authorized representative, Kahlia Harper, by telephone. Ms. Harper also provided documentation and written information via email on these days. Ms. Harper said Resident A's family does purchase wine and provides it to her. Specifically, Ms. Harper named FM1 and FM2, and Ms. Harper said these two are appointed as Resident A's Power of Attorney. When asked if those powers were enacted, say by a physician's determination, Ms. Harper said she did not know.

Ms. Harper said Resident A's physician said Resident A is to have no wine, and FM1 and FM2 have been informed of this physician's restriction to alcohol, but they are still providing it. Ms. Harper said when Resident A drinks wine she becomes violent and throws things. Ms. Harper said Resident A had been drinking wine and "appeared intoxicated" when she fell on 12/16 and 12/17/23.

On 01/04/2024, Ms. Harper provided a copy of Resident A's Durable Power of Attorney and Patient Advocate papers that appointed FM1 as her authorized representative, and FM2 as the successor, if FM1 is removed or unable to serve. According to the papers, FM1 may only advocate if Resident A becomes unable to participate in making decisions regarding medical treatment. It specifies that two physicians are to provide examination and determine when Resident A is unable to make medical decisions. Ms. Harper did not provide such a determination.

Ms. Harper also provided a copy of Resident A's service plan dated 11/10/2023. There is no mention in the service plan of Resident A's restriction from alcohol, nor of her drinking wine, nor of her becoming violent and throwing things when she drinks wine. Under "Fall Risk Reduction" it is checked "No Known History". Mobility and transferring are checked as "Independent". Under "Fluid Restrictions" it is written "No caffeine" and "Received Rx for no caffeine use decaf only".

Ms. Harper also provided a prescription dated 12/11/2023, that was signed by her physician's nurse practitioner. The prescription reads, "Pt should not be drinking alcohol due to medications + dementia". Ms. Harper provided *Daily Caregiver Checklist and Notes* pertaining to Resident A that included the following:

11/29/23 Shift: 1st Went out to lunch with daughter. Came back drunk walked into door. Dropped glasses outside facility.

12/6/23 Shift: 2nd Upset with someone taking her wine. No (sic) had taken her wine. She had drank (sic) it. First Shift emptied the trash with the empties in it.

12/14/23 Shift: 2nd She was drunk, need help w/putting on her pajams (sic) having hard time understanding me.

12/15/23 Shift: 1st She was very intoxicated, very aggressive to staff. She could barley (sic) stand up. Made a complaint to son on the 12/11/23 when Dr. Lisa came

and wrote a script for her to not drink wine anymore. But family keep (sic) bringing wine in for her to drink.

12/15/23 Shift: 2nd Had help her to toilet. She was drunk.

12/16/23 Shift: 1st shift She was frustrated about dentures. Other than (sic) she calm down. Resident was having a very hard time walking like she was drunk swaying back and fourth (sic). Had to be helped to couch after lunch. Could not walk on her own.

12/16/15 (sic) Shift: 2nd Resident having hard time walking. Complain of her right knee hurts. Resident fell by med room about 5:45 pm. Ambulance took her out. Son was called.

Ms. Harper also submitted two incident reports pertaining to Resident A. The first is dated 12/16/2023 at 5:35 pm and reads, “Fall. Not sure if she hit her head.” It also indicates EMS was called at 5:40 pm and she was sent to the hospital at 6:10pm.

The second incident report is dated 12/17/2023 at 8:35 am and reads, “Resident stood up to walk towards bathroom, and fell. [Staff #1] assured resident was okay and called ambulance. Additionally, called son (POA FM1) to inform them of the incident. Paramedics came out to evaluate resident via son’s request did not take her out to be treated. Vitals and neuro was (sic) good. Leg is swollen due to multiple falls.”

In the 01/04/2024 email that Ms. Harper attached the above documents, Ms. Harper wrote, “Good morning. Please see attached. I spoke with staff and they were under the impression the wine was removed at the end of December. However, as of yesterday evening, there was still wine in the room. I do not know if this is the original wine I observed or if more was brought in.”

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.**

For reference: R325.1901	**Definitions.**
	(p) "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:	Resident A has a 12/11/2023 nurse practitioner's prescription specifically reading, "Pt should not be drinking alcohol due to medications + dementia". The home documented subsequent events of Resident A appearing intoxicated on 12/14, 12/15, and 12/16/2023, and Resident A had falls on 12/16 and 12/17/2023. According to Ms. Harper's 01/04/2024 email, as of 01/03/2024, there was still wine in Resident A's room. Other than informing Resident A's family of the prescription, the home did not address Resident A's need to not be drinking alcohol. Therefore, the home did not maintain an organized program of protection of Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Resident A's service plan is dated 11/10/2023 and was submitted by Ms. Harper for my review on 01/04/204. Resident A had a 12/11/2023 nurse practitioner's prescription specifically reading, "Pt should not be drinking alcohol due to medications + dementia". Staff documented subsequent events of Resident A appearing intoxicated on 12/14, 12/15, and 12/16/2023 requiring staff assistance, and incident reports revealed Resident A suffered falls on 12/16 and 12/17/2023. As of 01/04/2024, Resident A's service plan was not updated to address these needs.

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: R325.1901	**(1) As used in these rules:**
	(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, and 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:	Resident A had a 12/11/2023 prescription to not be drinking alcohol, documented events of Resident A appearing intoxicated on 12/14, 12/15, and 12/16/2023 requiring care from staff to don her clothes and to walk, Resident A also had two documented falls on 12/16 and 12/17/2023 requiring EMS attention. As of 01/04/2024, Resident A's 11/10/2023 service plan was not updated after these significant changes of her care needs occurred.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 01/30/2024, I reviewed the findings of this report with the licensee's authorized representative, Kahlia Harper, by telephone.

IV. RECOMMENDATION

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

01/23/2024

Andrea Krausmann Date
Licensing Staff

Approved By:

01/30/2024

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