GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 21, 2024

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

RE: License #: AH250356639
Investigation #: 2024A1027080
McFarlan Home

Dear Licensee:

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 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,

Jessica Rogers

Jessica Rogers, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 285-7433
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH250356639
Investigation #:	2024A1027080
Complaint Receipt Date:	07/11/2024
Investigation Initiation Date:	07/16/2024
Report Due Date:	09/10/2024
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 lacked care and her medications.	Yes
Additional Findings	No

III. METHODOLOGY

04/12/2023	Special Investigation Intake 2024A1027080
07/16/2024	Special Investigation Initiated - Letter Email sent to complainant requesting additional information
07/16/2024	Contact - Document Received Email received from complainant with requested information
07/16/2024	Contact - Document Sent Email sent to Kahlia Harper requesting documentation pertaining to Resident A
07/26/2024	Inspection Completed On-site
07/26/2024	Contact - Telephone call made Telephone interview conducted with Employee #2
08/06/2024	Contact - Document Sent Email sent to Kahlia Harper requesting Resident A's service plan
08/14/2024	Inspection Completed-BCAL Sub. Compliance
08/21/2024	Exit Conference Conducted by email with Kahlia Harper and Christie Moyer

ALLEGATION:

Resident A lacked care and her medications.

INVESTIGATION:

On 7/11/2024, the Department received allegations forwarded from Adult Protective Services (APS) indicating that Resident A had repeatedly soiled herself and developed a bed sore that required three surgeries to address. The allegations

further claimed that the bed sore led to sepsis in both legs, and that Resident A did not have her blood sugar monitored or receive her insulin.

On 7/26/2024, an on-site inspection was conducted, and staff were interviewed. Authorized representative Kahlia Harper reported that Resident A was admitted on 12/16/2022, and discharged on 3/31/2023, and that she passed away on 4/18/2023. Ms. Harper noted that neither she nor the facility administrator were employed during Resident A's stay, so they could not speak on her care. Additionally, Ms. Harper stated she would continue to try to locate Resident A's service plan.

Employee #1 stated Resident A received every two-hour check and changes. Employee #1 stated Resident A occasionally used the call light properly but sometimes became incontinent if she was unwell. Employee #1 mentioned that Resident A had a bed sore and preferred to remain in her lift chair due to difficulty getting out of bed. Resident A used a wheelchair for mobility and required assistance from 2-3 people for transfers.

On 7/26/2024, a telephone interview was conducted with Employee #2 and corroborated Employee #1's statements. Employee #2 described Resident A as having an extensive medical history, including uncontrolled diabetes, and being dependent for her care needs. Resident A needed assistance from 3-4 people for transfers and had a buttock sore upon admission, for which creams were applied. Employee #2 also mentioned that Resident A had cellulitis and weeping in both lower legs, with care provided by an outside agency nurse. Employee #2 stated Resident A had a fall and was admitted to the intensive care unit in the hospital. Employee #2 stated Resident A experienced a fall and was admitted to the intensive care unit (ICU) before being transferred to a skilled nursing facility for rehabilitation, then back to the ICU, where she eventually passed away.

A review of Resident A's face sheet confirmed details provided by Ms. Harper, noting that Relative A1 was her power of attorney and Relative A2 was her second contact. The face sheet also indicated that Resident A was on 4 liters of oxygen.

Examination of Resident A's medication administration records (MARs) from December 2022 to March 2023 showed she was prescribed Eucerin for her lower extremities, Lantus daily, metformin, and Novolog three times daily. The MARs read in part staff initialed administered medications and marked medications that were not given, along with the reasons for any exceptions. While the MARs did not require blood glucose documentation, the December 2022 MAR indicated glucose levels ranging from 78 to 345.

Additionally, the January 2023 MAR noted Resident A was out of the facility from 1/22/2023 to 1/24/2023. The February 2023 MAR indicated Resident A was out of the facility from 2/8/2023 to 4/21/2023.The March 2023 MAR recorded no medications administered.

Review of facility rounding forms dated 12/18/2022, to 12/31/2022, showed that checks were conducted every two hours on the first and second shifts and hourly on the third shift, with staff signatures indicating completion.

Review of care logs dated 1/1/2023 through 2/8/2023 noted Resident A used a wheelchair and that staff were to assist with applying a clean brief and dressing, as well as transporting her to the living room. The logs read in part staff initialed those tasks were completed as well as noted if she had bowel movement that day. Staff signed off on these tasks and recorded any bowel movements. Additionally, the logs indicated that staff were to switch Resident A from her portable oxygen tank to the concentrator. Staff notes read in part Resident A was incontinent and declined care at times. Additionally, review of the care logs dated 2/9/2023 through 3/1/2023 read consistent with the Resident A's MARs reflecting she was out of the facility.

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.**
	(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:	Staff attestations indicated that Resident A had a significant medical history and was dependent on care, though she sometimes refused it. Although the review of facility records did not provide enough evidence to support claims of inadequate care or medication management, the facility lacked a service plan detailing Resident A's specific care need. This absence of a service plan prevented an accurate evaluation of the care provided; therefore, a violation was substantiated due to the lack of a service plan to properly assess the care delivered.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of this license remain unchanged.

08/15/2024

Jessica Rogers Date
Licensing Staff

Approved By:

08/20/2024

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