

MICHIGAN DEPARTMENT OF CONSUMER & INDUSTRY
Bureau of Regulatory Services
Home for the Aged Program

FOIA

Consultation Visit
Opening/Initial Survey Report

Facility No: 25-9102
Facility Name: Homewood Residence @ Genesee
Valley
Address: 4444 West Court Street
City: Flint, Michigan 48532
County: Genesee
Telephone Number: ()
Fax Number: ()
Date: 1/28/2000

Announced Consultation Visit
Nurse Consultant: Janice Pettengill, R.N.
H.F.A. Coordinator/Consultant

PARTICIPANTS:

John Merlo, Residence Manager
Kolette Nelson, Regional Director of Operations

Robert Kerns, Auditor from MDCIS Management & Budget

GENERAL INFORMATION:

An initial, on-site survey and consultation visit was conducted 1/21/2000 to determine if the new facility's policy/procedures and systems were complete and met the intent of the Home for the Aged (HFA) licensure requirements. Feedback and consultation were provided during the visit.

A tour of two of the four buildings was conducted. There are two, single story buildings, that are identical and are designated as homes for residence with dementia. These homes are referred to as Arbor's Alzheimer's Care Centers. The other two buildings (which are located on the same campus) are multiple story assisted living homes. The buildings are still under construction but roughed in so that the layout could be viewed during the tour. Residents have several room, floor plans that they can select from. The facility is requesting 110 licensed beds: 15 beds in private rooms in each of the two dementia homes, and 40 beds in each

assisted living building.

Three levels of care are to be offered. In the larger buildings, the levels of care are referred to as: Independent (Basic), and Assisted Living. The dementia homes are special care homes designed for residents with cognitive impairments that can not effectively function in a traditional HFA.

The facility goal is to be approved for licensure on or about March 16, 2000. MDCIS Engineer plans to schedule a final inspection around that time.

The materials presented for review were corporate policies/procedures and other related documents adapted for use in Michigan. Much time was spent discussing the need for additional information, revisions and refinements of the presented Policies/Procedures.

COMMENTS - SPECIFIC KEY AREAS TO BE COMPLETED:

1. Recommend that the Mission/philosophy of care & services statements incorporate the entire legal definition of the HFA (e.g. providing room, board/meals, and supervised personal care/ with activities of daily living and medication administration assistance for residents 60 years of age or older, unless an age waiver is obtained). Also provide Age Waiver policy/procedure. The departments requirements are enclosed.
2. Send a statement on letterhead stationery clarifying if the facility will or will not be handling residents' monies. If residents' monies (including security deposits; pet deposits; smoking deposits) are held by the facility for the resident, the policy/procedure including accounting procedures must be provided. A Surety Bond of 1 and 1/4 of the yearly average total amount of funds held must be provided.
3. Provide the facility's Smoking Policy/Procedure (address if the building is smoke free, or if smoking is allowed in specific designated areas and specify where, even if out doors).
4. Provide a complete Resident's Rights & Responsibilities document that incorporates all the rights and the responsibilities as stated in Section 20201 & 20202 of the Public Health Code. House rules (which are not regulations) may be incorporated into the responsibilities portion of this document. Use one complete document when references are made to Residents' Rights & Responsibilities. Providing the Residents' Rights and Responsibilities verbally and in writing, as well as, staff trained in knowing and implementing them, needs to be included in the Resident Agreement/document; resident and staff orientation documents.
5. The Resident Agreement needs revision. Differentiations pertinent to the special care dementia unit and the assisted living program need to be incorporated. Clarification of when the facility is responsible for a resident's property (page 7) ~~delete due to theft and any~~ (leave other causes). In the last sentence, where insurance is recommended, ~~delete at~~

coverage and liability limits that are acceptable by us. This is a resident's own business and right to determine coverage and amount.

The facility is responsible for residents' and others belongings when it is due to employee negligence; misconduct; and misappropriations. The facility must also provide a safe environment for this vulnerable population living there. An even higher standard of care and protection is needed and necessary for the residents in the Special Care /Dementia Unit, where residents have cognitive impairments and are dependant on staff. These safeguards and facility protections need to be included and clarified.

The facility contract may want to indicate how resident's safety and well being are provided for by providing rooms with locks in assisted living.

Change the department name to the Department of Consumer and Industry Services (page 8 plus all other documents).

Add item: Q. Resident Rights & Responsibilities document has been explained and a copy received. (Note: Proof/documentation of receipt of this document is in each resident's file).

Appendix A indicate if Smoking deposit is non-refundable. If that is the case, a surety bond is not needed to cover this deposit. Referring to it as a fee might be more appropriate if non-refundable.

Appendix B needs to include Hospice care if that is a consideration. Policies/Procedures would also need to be submitted pertinent to Hospice care if it is offered.

Appendix C needs to refer to the Resident's Bill of Rights and Responsibilities.

6. Clarify some specific criteria for Admission & Discharge Policies/Procedures. For example: -Shall not accept or sustain a resident who lacks the ability to feed oneself, or is immobile or staff and resident are not able to manage incontinence. Policy/procedure for residents using electric wheelchairs needs to indicate that this will be evaluated on an individual basis and that a resident must be able to safely drive the electric wheelchair.

Also differentiate between episodic care and chronic, continuous care. Indicate if Respite and Hospice residents would be considered on an individual basis to remain in the facility and that the Hospice RN will direct the care of Hospice residents. Provide a specific Respite and Hospice Policy/Procedure.

7. The Complaint/Grievance Policy/Procedure needs to include any allegations of abuse, neglect, suspicious or unwarranted deaths, or exploitation/misappropriations of resident's property. The facility should do their own immediate investigation and the Department should be notified at 1-800-882-6006. (This number will change when HFA moves and is housed under the Bureau of Regulatory Services).

8.. The requirements for TB screening need to reflect Michigan law

interpretation as clarified in the TB Clarification letter provided. Incorporate in all Policy/Procedures where TB testing is mentioned.

9. Provide the Accident and Incident Policy/Procedures to be used. Include definitions and examples: omissions of care, elopement(s), missing articles, abuse, neglect, and exploitation; and form(s). Explain who is responsible for filling out the form(s), notifications, and corrective actions.

10. Include in Death Policy/Procedure that the Department is to be notified of unexpected, unwarranted, or suspicious deaths. Include that a medical emergency should be responded to per the resident's Advance Directive and/or Do not Resuscitate Order per Michigan law (P/P 2.01 & 2.02).

12. The Medication Administration Policy/Procedure must be specific to the system used and must include the 5 Rights of Medication Administration (Right Resident; Right Medication; Right Dosage; Right Route; **Right Frequency/Time**) when preparing, administering, and charting medication(s) given. The various policies/procedures need to specify who is authorized to give the medications e.g. oral meds., injections; and who is monitoring potential side effects. A policy/procedure for injections is needed with specification as to who can give injections under Michigan law. Provide Self Administration of Medication Policy/Procedure including qualifications and determination criteria & methods. Provide training module for unlicensed staff giving medications, and indicate how the full time RN is responsible for oversight, delegation, training, supervision and monitoring of staff providing care, including medication administration, in the memory impaired/dementia program/homes. Indicate that controlled drugs are to be destroyed by two designated staff members, documented, and witnessed. Pharmacy should be able to provide a proper form to use.

Provide Policy/Procedure regarding physician's/prescriber's orders, both written, faxed, and verbal. (Note only licensed staff and Pharmacists can take verbal orders that must be countersigned by the authorized provider/physician). Encourage written orders. Faxed orders that are signed and dated are acceptable.

Diet Restrictions needs to delete restrictions and the first diamond needs to indicate obtain diet orders **including therapeutic diet orders**.

13. The Confidentiality of Resident Records (P/P 1.22) needs to also indicate that release of personal information/resident information also includes **as permitted by law** (Rule 53). Also indicate who can access resident records; make **copies**; and how are records secured so that only authorized people can access them. **Clarify** that resident records will be retained "in house" for one year **and longer if it is the most recent document**.

14. Based on our discussion, provide a letter from your dietitian indicating that regular and **therapeutic diet menus** have been reviewed for nutritional adequacy and appropriateness. Also indicate that the dietitian is available for consultation regarding therapeutic menus as needed. Regarding Sodium Restricted Diets: state salt is not used in cooking and

condiments are available as is appropriate. Indicate that Therapeutic diets will be prepared and served per physician's orders. Provide information as to how likes & dislikes will be addressed. Provide the Policy/Procedure on Monitoring Weights and explain how weight gain and weight loss will be addressed.

15. Also provide specific Resident Assessment Policy/Procedures which include assessments prior to admission to determine needs and proper placement, as well as, provisions for on-going assessments when changes occur. Indicate when cognitive assessments are done and who does the cognitive assessment and how this information is utilized. Provide a copy of the assessment tools and care plan format to be used.

16. Provide a Policy/Procedure for Maintenance to routinely check water temperatures so hot water does not exceed 120 degrees Fahrenheit. The acceptable range for hot water temperatures is 105 to 120 degrees Fahrenheit.

17. A specific Disaster Policy/Procedure for power outages needs to be submitted.

18. A procedure for toxic substance data sheets made available to staff, and an provision of an eye wash station.

19. Laundry procedures need to state how the specific facility will be handling the laundry (not a generic policy/procedure) but on an individual basis.

20. The submitted staffing plans should indicate that the proposed plans are minimum staffing for the traditional HFA and additional staff will be provided as needed to meet the needs of the residents. A separate staffing plan needs to be submitted for the Dementia Unit. This needs to include a full time RN that gives oversight; assesses residents; trains staff and supervises their care; monitors residents; and delegates as is appropriate. A staff member must always be present in the Dementia Unit. Indicate whether outside pool staff will be utilized, and if so, indicate under what conditions; how is proper screening done; and orientation to the facility's policies/procedures accomplished (P/P 1.28 & Private Duty Agreement) needs to include adherence and support of ARC philosophy/policies/procedures and successful completion of facility orientation.

Also note that admissions should not exceed more than two new residents per day nor five per week until full census is achieved.

21. Death of a Resident P/P needs to include:

- Notification of a death needs to include the physician.
- Procedure needs to clarify Advance Directives, emergency procedures; and the Do Not Resuscitate Law in Michigan(a copy is enclosed).

22. Provide a Policy/Procedure (specify P/P for traditional HFA & Memory Loss Units) regarding alarm/security systems; wandering; and missing residents P/P (2.06): If the resident has not signed out (add) **and is not accounted for:**. Include notification of family and physician; and when to notify HFA state licensure office. When the resident is located indicate

follow up given the resident's condition and presenting signs and symptoms.

23. Up date Hand washing Policy/Procedure so that it reflects the actual Hand washing that is to be done with soap and water whenever possible.

24. The document on Universal Precautions needs to be revised & expanded as discussed. (Delete concept of double bagging & use of red bags). Also provide the Orientation plan for employees regarding the risk of Hepatitis B and the offering of the Hepatitis B Vaccine (HBV) within the first 10 days of employment. Include a written consent or declination regarding HBV is to be placed in each employee's file. Hepatitis B exposures (indicate) an incident report needs to be completed.

Also refer to the Blood borne Infectious Disease document enclosed.

25. Provide new employee orientation and a complete Orientation Checklist, Resident Rights & Responsibilities; expand list of violations of Rights that are to be reported to the HFA program; Accident & Incident Reporting including taking corrective action; Advance Directives and Emergency Care. Also indicate all such information that is to be placed in each employees file.

26. Provide the Special Care/Dementia Unit Program statement, policies/procedures; staffing plan; and Quality Assurance Program Measures that provide the framework for an effective Dementia Care Program. Address each component of the program as outlined in the "HFA Specialized Units For Dementia" document provided.

27. Provide the administrator's resume.

28. Provide policies/procedures regarding reporting communicable diseases. Enclosed is a copy of "Health Care Guide To the Michigan Communicable Disease Rules" for your use.

29. Clarify what staff will be transporting residents in vehicle(s). Indicate what screening is used in allowing staff to drive residents.

30. If Day Care or Respite Care is provided, provide specific policies/procedures indicating how this will be accommodated, under what conditions, and how staffed.

SUMMARY:

The administrator indicated that he and the corporate personnel would be acting quickly to provide the needed information identified and in many instances their facilities addressed the issues raised. The following additional information will be immediately sent: Immediate staffing plan; Staff Training Manuals & corresponding Orientation Checklists; Personal Service Plan; and Food Service Policy/Procedure Manual.

It is the intent of the facility to be in licensure compliance by mid-March 16, 2000. The needed documents stated in this report must be submitted and approved prior to opening.

Licensure will be granted once these requirements are met and the State Engineering and Fire Safety offices have reported approval after their final inspections.

Enclosed is requested information that we discussed which you may find useful:

- Copy of the Department's Age Waiver Policy/Procedure.
- Clarification letter and screening questionnaire of TB Screening Requirements in HFA.
- "Health Care Professional Guide to the Michigan Communicable Disease Rules".
- Information regarding "Blood borne Infectious Disease".
- Do Not Resuscitate Michigan Law/Senate Bill #451.
- Dementia Unit/Special Care Unit Guidelines

Please direct any questions you have regarding this report and accompanying materials to Janice Pettengill, telephone # (517) 241-3839. Questions regarding the progress of the licensure paperwork may be directed to Jackie Cordier, HFA Secretary at (517) 241-3838.

Respectfully Submitted,


Janice Pettengill, RN Date
HFA Coordinator/Consultant

cc Riyadh Almukhtar; Jean Myers; Glen Kralapp; File

MICHIGAN DEPARTMENT OF CONSUMER & INDUSTRY SERVICES
BUREAU OF HEALTH SYSTEMS/DIVISION OF HEALTH FACILITY LICENSING AND CERTIFICATION
SPECIAL SERVICES SECTION
P.O. BOX 30664/LANSING/MI/48909

HOME FOR THE AGED LICENSE APPLICATION

1. TYPE OF APPLICATION: Initial Amendment Change of Ownership Licensed Bed Changes
2. FACILITY NAME: McLaren Homewood Village
3. FACILITY PHYSICAL ADDRESS: 4444 West Court Street
(Street)
Flint MI 48532 Genesee
(City) (State) (Zip) (County)
4. FACILITY MAILING ADDRESS IF DIFFERENT THAN PHYSICAL ADDRESS:
(Street)

(City) (State) (Zip) (County)
5. MAIN/GENERAL PUBLIC PHONE NUMBER: (810) - 720 - 5184
6. FAX NUMBER: (810) - 720 - 5187
7. TOTAL NUMBER OF BEDS TO BE LICENSED: 228
(For license fees contact our office (517) 241-3838. Fees are prorated based on open date within the billing cycle of 8/1 through 7/31 of each year and the per bed fee of \$6.27. Change of Ownership and bed increase fees are equal to 1 year fee regardless of billing cycle. Do not send fees until you receive an Invoice from D.C.I.S.)
8. ADMINISTRATOR:
 - A. Name: Mr. John L. Merlo
(Salutation) (First) (Middle Initial) (Last)
 - B. Administrative/Emergency Phone Number: (810) - 750 - 2181
 - C. Hire Date of Administrator at Provider: 9/15/99
9. OWNERSHIP (legal entity which directly owns the facility):
 - A. Company/Owner Legal Name: Flint Michigan Retirement Housing LLC
 - B. Company/Owner Address: 401 S. Ballenger Hwy. Flint MI 48532
(Street) (City) (State) (Zip)
 - C. Company/Ownership Start Date: 8/7/98 D. Company/Ownership End Date: _____
 - E. Company/Owner Phone: (615) - 221 - 2250
 - F. Federal ID Number: 38-3444695
 - G. Primary Owner or Contact: Ms. Ellen L. Mayfield
(Salutation) (First) (Middle Initial) (Last)

H. Type of ownership: _____ Individual _____ State
 _____ Partnership _____ County
 _____ Corporation _____ City
 _____ Non-Profit Church _____ City/County
 _____ Non-Profit Other _____ Hospital Authority
 _____ Other (Specify) _____

I. Corporation officers/directors/trustees: (Attach additional pages if necessary.)

First Name	Last Name	Address
N/A		

J. Individuals with 5% or more interest: (Attach additional pages if necessary.)

First Name	Last Name	Percent of Interest
N/A		

K. Are any persons who have an ownership interest required to file a beneficial ownership report pursuant to the Federal Securities Exchange Act of 1934 [15 U.S.C. 78p, Sec. 16(a)]?

Yes: _____ No: If yes, attach copies of such reports.

10. PARENT ORGANIZATION:

If the entity indicated in 10(A) is owned by a parent organization, please complete the following:

Parent Organization Name: _____

Address: _____
 (Street)

 (City) (State) (Zip)

11. CERTIFICATION BY APPLICANT:

A. Authority: P.A. 368 of 1978 as amended. The Issuance and processing of this form is governed by Administrative Rules 325.20201 through 325.20215. Failure to submit an accurate and complete form in a timely manner may result in denial of licensure or certification. An applicant who makes a false statement in this application is subject to criminal penalties under Section 20142(5) of the Public Health Code (P.A. 368 of 1978 as amended).

B. The applicant certifies that the information provided on this application is true, complete and accurate to the best of his/her knowledge.

Applicant's Name: Sheryl Ludeke-Smith Officer
 (First) (Middle Initial) (Last) (Title)

Telephone Number: (615) - 221 - 2250

Applicant's SIGNATURE: Sheryl Ludeke-Smith Date: 1-24-01

Rec'd 12/1/99

MICHIGAN DEPARTMENT OF CONSUMER & INDUSTRY SERVICES
BUREAU OF HEALTH SYSTEMS/DIVISION OF HEALTH FACILITY LICENSING AND CERTIFICATION
SPECIAL SERVICES SECTION
P.O. BOX 30664/LANSING/MI/48909

HOME FOR THE AGED LICENSE APPLICATION

1. TYPE OF APPLICATION: Initial Amendment Change of Ownership Licensed Bed Changes
2. FACILITY NAME: Homewood Residence at Genesee Valley
3. FACILITY PHYSICAL ADDRESS: 4444 West Court Street
(Street)
Flint MI 48532 Genesee
(City) (State) (Zip) (County)
4. FACILITY MAILING ADDRESS IF DIFFERENT THAN PHYSICAL ADDRESS:
(Street)
(City) (State) (Zip) (County)
5. MAIN/GENERAL PUBLIC PHONE NUMBER: (810) - 720 - 5184
6. FAX NUMBER: (810) - 720 - 5187
7. TOTAL NUMBER OF BEDS TO BE LICENSED: 228
(For license fees contact our office (517) 241-3838. Fees are prorated based on open date within the billing cycle of 8/1 through 7/31 of each year and the per bed fee of \$6.27. Change of Ownership and bed increase fees are equal to 1 year fee regardless of billing cycle. Do not send fees until you receive an Invoice from D.C.I.S.)
8. ADMINISTRATOR:
 - A. Name: Mr. John L. Merlo
(Salutation) (First) (Middle Initial) (Last)
 - B. Administrative/Emergency Phone Number: (810) - 750 - 2181
 - C. Hire Date of Administrator at Provider: 9/15/99
9. OWNERSHIP (legal entity which directly owns the facility):
 - A. Company/Owner Legal Name: Flint Michigan Retirement Housing LLC
 - B. Company/Owner Address: 401 S. Ballenger Hwy Flint MI 48532
(Street) (City) (State) (Zip)
 - C. Company/Ownership Start Date: 8/7/98 D. Company/Ownership End Date: _____
 - E. Company/Owner Phone: (615) - 221 - 2250
 - F. Federal ID Number: 38-3444695
 - G. Primary Owner or Contact: Ms. Ellen L. Mayfield
(Salutation) (First) (Middle Initial) (Last)

Please see attached

H. Type of ownership:

<input type="checkbox"/>	Individual	<input type="checkbox"/>	State
<input checked="" type="checkbox"/>	Partnership	<input type="checkbox"/>	County
<input type="checkbox"/>	Corporation	<input type="checkbox"/>	City
<input type="checkbox"/>	Non-Profit Church	<input type="checkbox"/>	City/County
<input type="checkbox"/>	Non-Profit Other	<input type="checkbox"/>	Hospital Authority
<input type="checkbox"/>	Other (Specify) _____		

I. Corporation officers/directors/trustees: (Attach additional pages if necessary.)

First Name	Last Name	Address
N/A		

J. Individuals with 5% or more interest: (Attach additional pages if necessary.)

First Name	Last Name	Percent of Interest
N/A		

K. Are any persons who have an ownership interest required to file a beneficial ownership report pursuant to the Federal Securities Exchange Act of 1934 [15 U.S.C. 78p, Sec. 16(a)]?

Yes: No: If yes, attach copies of such reports.

10. PARENT ORGANIZATION:

If the entity indicated in 10(A) is owned by a parent organization, please complete the following:

Parent Organization Name: _____

Address: _____

(Street)

(City) (State) (Zip)

11. CERTIFICATION BY APPLICANT:

A. Authority: P.A. 368 of 1978 as amended. The Issuance and processing of this form is governed by Administrative Rules 325.20201 through 325.20215. Failure to submit an accurate and complete form in a timely manner may result in denial of licensure or certification. An applicant who makes a false statement in this application is subject to criminal penalties under Section 20142(5) of the Public Health Code (P.A. 368 of 1978 as amended).

B. The applicant certifies that the information provided on this application is true, complete and accurate to the best of his/her knowledge.

Applicant's Name: Donald L Husi Sr. Vice President Operations
(First) (Middle Initial) (Last) (Title)

Telephone Number: (615) 221-2250

Applicant's SIGNATURE: Donald L. Husi Date: 11/29/99

Exhibit "A"

<u>Members Name and Address</u>	<u>Capital Contribution</u>	<u>Membership Percentage</u>
ARC Flint, Inc. 111 West Wood Drive Suite 402 Brentwood, Tennessee 37027		37.50%
McLaren Medical Management, Inc. 401 South Ballenger Highway Flint Michigan 48532		37.50%
FP Flint, L.L.C. 1355 Piccard Drive Suite 400 Rockville, Maryland 20850		25.00%
Total		<u>100.00%</u>

Certificate of Appointment for Authorized Representative

Homewood Residence at Genesee Valley
Name of Facility
444 West Court Street Flint 48532
Address City Zip

Notice is hereby given to the Michigan Department of Consumer and Industry Services in accordance with a provision of Rules for Nursing Homes, Homes for the Aged, or Freestanding Surgical Outpatient Facilities, that:

Flint Michigan Retirement Housing, LLC has appointed
(Owner of facility requesting license and/or certification)

John Merlo as its authorized representative to:
(Name)

- a. Submit applications and make amendments thereto.
- b. Provide the department with all information necessary for a determination with respect to applications.
- c. Enter into agreements with the department in connection with licensure or certification.
- d. Receive notice and service of process in matters relating to licensure or certification.

This action taken on 9/15/99 and is effective immediately.
(Date)

This appointment will remain in effect until written notice of termination is sent to the Director, Bureau of Health Systems, Michigan Department of Consumer and Industry Services, or until the next license application is filed with the department.

Donald P. Kerei 11/29/99
Signature of Owner
Senior Vice President, Operations
Title

Witness: Ellen Mayfield

Date: 11/29/99

Witness: Natalie Lambert

Date: 11/29/99