GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 27, 2021

Nicole Kennedy
McGivney Way
610 W Elm Ave
Monroe, MI 48162

RE: License #: AH580402316
Investigation #: 2021A0585046
McGivney Way

Dear Ms. Kennedy:

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. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (571) 284-9730.

Sincerely,

Brender L. Howard

Brender Howard, Licensing Staff
Bureau of Community and Health Systems
4th Floor, Suite 4B, 51111 Woodward Avenue
Pontiac, MI 48342
(313) 268-1788
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH580402316
Investigation #:	2021A0585046
Complaint Receipt Date:	08/18/2021
Investigation Initiation Date:	08/19/2021
Report Due Date:	10/17/2021
Licensee Name:	IHM Senior Living Community, Inc
Licensee Address:	610 W Elm Ave Monroe, MI 48162
Licensee Telephone #:	(734) 240-9743
Administrator/Authorized Representative:	Nicole Kennedy
Name of Facility:	McGivney Way
Facility Address:	610 W Elm Ave Monroe, MI 48162
Facility Telephone #:	(734) 241-3660
Original Issuance Date:	07/28/2020
License Status:	REGULAR
Effective Date:	01/28/2021
Expiration Date:	01/27/2022
Capacity:	28
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A fell during the power outage and was not found until the next morning.	Yes
Electrical power was lost in the facility.	Yes
Additional Findings	No

The complainant identified some concerns that were not related to licensing rules and statutes for a home for the aged. Therefore, only specific items pertaining to homes for the aged provisions of care were considered for investigation. The following items were those that could be considered under the scope of licensing.

III. METHODOLOGY

08/18/2021	Special Investigation Intake 2021A0585046
08/19/2021	Special Investigation Initiated - Letter Emailed a referral to Adult Protective Services (APS) regarding the allegations.
08/24/2021	Inspection Completed On-site Completed with observation, interview, and record review.
09/01/2021	Contact Document Sent Requested additional documents from the administrator/authorized representative Nicole Kennedy.
09/02/2021	Contact Document Received Requested documents received.
09/27/2021	Exit conference. Conducted with authorized representative Nicole Kennedy.

ALLEGATION:

Resident A fell during the power outage and was not found until the next morning.

INVESTIGATION:

On 8/17/21, the department received an anonymous complaint alleging that during the power outage, Resident A fell and was found in the bathroom lying on her back in a pool of blood. The complaint alleged that Resident [A] was pounding on the wall and trying to find the light switch. Due to the anonymous nature of the complaint, additional information could not be obtained.

On 8/24/21, I conducted on onsite inspection. I interviewed administrator Nicole Kennedy at the facility. Ms. Kennedy stated that there was a total of 23 residents during the power outage. She stated that Resident A was independent and would get irritated when staff come in her room. She stated that Resident A was found in her bathroom with her feet up on the toilet. She stated that she wasn't on the floor long because the blood that was on her head was fresh. She stated that Resident came out of her room around 1:30 a.m. talking to staff. She stated the staff walked Resident A back to her room and put her in the bed. She stated that Resident A normally gets up in the morning at 6:00 a.m. and was unsure what time she was last checked on. Ms. Kennedy explained that during the outage, the hallway lights were illuminated, and the resident's door was closed. She said, Resident A would normally close her door as she didn't like being woken in the middle of the night.

The facility incident report for Resident A read, "on 8/13/21 resident was found on her bathroom floor by staff at 6:45 a.m. She was lying on the floor on her back with her legs extended outward with her feet on the toilet seat. Upon assessment of resident a 5-inch laceration to her forehead was noted. 911 was notified immediately and resident was given a washcloth to place on her head until ambulance arrived. Nurse stayed with resident until ambulance arrived at 7:05 a.m."

I interviewed nursing supervisor Shawna Valeri during the onsite. She stated that the facility has a generator and they also used flashlights to check on residents every 30 minutes.

I interviewed care aide Emilee Ickes by telephone. She stated that during the power outage, they completed 30-minute checks on all residents. She stated that she saw Resident [A] between 12:30/1:00. She stated with two of them working memory care, they each took a hallway. She stated that she did not work the hallway that Resident A was on and didn't know whether she was checked on after she took her back to the room around 1:30 a.m. She stated that Resident A did not like anyone to come by her room and would get upset if anyone checked on her during the night. She stated that Resident A was independent.

Several attempts were made to contact care aide Bethany Rimmer by telephone. As of the date of this report, no return call has been received. Ms. Kennedy explained that they have also made attempts a few times to reach Ms. Rimmer but with no response and that Ms. Rimmer no longer is employed with the facility.

The service plan for Resident A read, independent with transfers, and toileting. Resident A will at times get angry but is redirected or distracted easily and usually calms down quickly. The service plan does not address Resident A's competency; however, it does read that she is steady with ambulation, independent with grooming, chooses her own clothing to wear and does not have any incontinence concerns for bladder or bowel.

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.**
ANALYSIS:	Resident A has dementia and resides within secured memory care for her protection. It could not be determined that Resident A was monitored with adequate frequency. In addition, during the loss of power resident rooms were not illuminated and the hallway outside the resident rooms only a little. While Resident A's plan and others may have been adequate during normal electrical operations, the fact that Resident A had to navigate within her dark room to a dark bathroom was not reasonable expectation for a resident with dementia. Nor is reasonable for staff to time bathroom needs during sleep hours based on a thirty-minute schedule. Staff took no reasonable action beyond claiming to have monitored the 23 residents every 30 minutes. The absence of an organized plan of safety measures implemented within areas of resident use, led to Resident A's accident with injury.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Electrical power was lost in the facility.

INVESTIGATION:

The complaint alleges that on 8/12/21, the facility lost power and there were no lights in the residents' rooms and only a faint light in the hallway.

Ms. Kennedy informed me on 8/12/21, that the facility had lost power and DTE had been contacted.

Ms. Kennedy stated that the facility had a power outage which was reported to the State. She stated that when the lights were off, they were on the backup generator. She stated the power was out from 3:45 p.m. that evening until 7:30 pm the next day. She stated that there was air conditioner in the sitting room and the temperature was comfortable. She stated that temperatures were checked every hour. Ms. Kennedy stated that when the power was out, all residents were on 30-minute checks. She stated that sensor lights have been installed since the power outage for all resident's room. Ms. Kennedy explained that most foods served during the outage were cold foods such as salads with chicken, sandwiches, and other refrigerator items that came straight from the main kitchen. She said that they were able to make a few warm items with the steam kettles and gas range located in the main kitchen. She stated that paper/plastic products such as silverware, paper plates, cups, and trays were used during the outage. Ms. Kennedy explained that the phone service was working during the outage. She said the temperatures never raised above 81 degrees and residents' windows were open in the evening to allow for cooler air to come in. She said that they also had fans and a portable air conditioner in place to keep the residents cooler if they were feeling warm. Ms. Kennedy stated that they checked the temperature throughout the outage and kept a record of the temperature.

Ms. Ickes stated that most of the residents are quiet during the night, but on the night of the power outage, the residents were up and down due to it being hot. Ms. Ickes stated that Resident A was the only fall that happened on the night of the power outage.

The review of the temperature record was consistent with Ms. Kennedy's statement.

The facility *Emergency Plan* read

> *Purpose: The purse of this emergency plan is to provide specific procedures that must be followed by all staff for the safety and well-being of the residents in the Home for the Aged until at IHM Senior Living Community.*
>
> *<u>Loss of Power</u>: In the event of a major power failure, staff should notify the designated supervisor and contact Security at Ext. 888.*
>
> *Should there be a loss of power, the generator will provide the following power to the HFA: Emergency lighting in the corridor, emergency exit lighting, fire alarm, power to the boilers for corridor heating, telephone system, and vigil system.*

Staff should: relocate residents to a well-lit area for their safety, inform the HFA supervisor of the resident location and power issues. The HFA supervisor or shift supervisor must contact security. Wind up style flashlights are available in the resident go kits for each resident. These are located in B-314a if needed. The HFA supervisor or shift supervisor will inform staff when it is necessary to contact residents' authorized representative in an extended power outage. For residents using oxygen concentrators or any electrically powered medical equipment, accommodations can be made in the skilled care area to access generator powered emergency outlets. The HFA supervisor or shift supervisor will contact the executive director to have such accommodations made. The HFA supervisor or shift supervisor must contact dining services to inform them of the need for tray-style service since the HFA kitchen equipment will not function. The HFA supervisor or shift supervisor must consult with dining services to determine the need to throw away food that could have potentially spoiled in the event of an extended power outage. The facility's dish machine will also be disrupted during a power outage. Disposable paper products will be used if the dish machine is not available for any meal.

Maintenance and/or Security staff will verify that the equipment on emergency power is functioning. The facilities manager will contact DTE Energy to notify them of the power outage and receive updates as possible. If the outage is expected to be for an extended period, the fuel supplier for the generator will be contacted to provide fuel until the power is restored. The generator can function for well over 24 hours with a full tank of fuel.

The 15 second delayed egress doors located at each end of the unit will not function without power. The doors will be unlocked without power. During a power outage, staff should regularly perform head counts or take attendance of the residents at least every half hour.

APPLICABLE RULE	
R 325.1981	**Disaster plans.**
	(1) A home shall have a written plan and procedure to be followed in case of fire, explosion, loss of heat, loss of power, loss of water, or other emergency.

ANALYSIS:	The facility was without power for more than a 24-hour period. The staff did not follow the loss of power plan by ensuring that they "*relocate residents to a well-lit area for their safety"* or some other implemented method to limit risk if staff allow residents to remain within a dark room. The loss of power plan was not adequately developed for the loss of power conditions and the act of allowing residents to remain within their rooms.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 9/27/21, I conducted an exit conference with licensee authorized representative Nicole Kennedy by telephone.

IV. RECOMMENDATION

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

Brender L. Howard 9/27/21

Brender Howard Date
Licensing Staff

Approved By:

Russell Misiak 9/27/21

Russell B. Misiak Date
Area Manager