GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 17, 2021

Richard Dible
Pilgrim Manor
2000 Leonard Street
Grand Rapids, MI 49505

RE: License #:	AH410387636
Investigation #:	2021A1021041
	Pilgrim Manor

Dear Mr. Dible:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated by the authorized representative.

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 (517) 284-9730.

Sincerely,

Kimberly Horst, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH410387636
Investigation #:	2021A1021041
Complaint Receipt Date:	08/09/2021
Investigation Initiation Date:	08/11/2021
Report Due Date:	10/08/2021
Licensee Name:	United Church Homes, Inc.
Licensee Address:	170 East Center Street Marion, OH 43301
Licensee Telephone #:	Unknown
Administrator:	Emily Alt
Authorized Representative:	Richard Dible
Name of Facility:	Pilgrim Manor
Facility Address:	2000 Leonard Street Grand Rapids, MI 49505
Facility Telephone #:	(616) 458-1133
Original Issuance Date:	05/29/2018
License Status:	REGULAR
Effective Date:	11/29/2020
Expiration Date:	11/28/2021
Capacity:	103
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Facility lost Resident A's hearing aids.	No
Additional Findings	Yes

III. METHODOLOGY

08/09/2021	Special Investigation Intake 2021A1021041
08/11/2021	Inspection Completed On-site
08/13/2021	Contact-Documents Received Received MAR, service plan, and admission agreement for Resident A
08/23/2021	Contact-Documents Received Received MAR and TAR for Resident A
09/17/2021	Exit Conference Exit conference with interim administrator Wendell Torrey

ALLEGATION:

Facility lost Resident A's hearing aids.

INVESTIGATION:

On 8/9/21, the licensing department received a complaint with allegations the facility lost Resident A's hearing aids. The complainant alleged the facility was to keep the hearing aids locked in the medication cart and did not do so. The complaint was sent from Adult Protective Services.

On 8/11/2021, I interviewed executive director Wendell Torrey at the facility. Mr. Torrey reported if an item comes up missing the facility will attempt to locate the missing item. Mr. Torrey deferred to the administrator Emily Alt on the details regarding the missing hearing aids.

I interviewed Ms. Alt at the facility by telephone. Ms. Alt reported Resident A has severe memory loss and can be combative with staff. Ms. Alt reported Resident A will fuss with her belongings and often misplaces items. Ms. Alt reported Resident A

has one hearing aid that is to be locked in the medication cart at night and placed back in Resident A's ear in the morning. Ms. Alt reported this task is to be completed by the resident care associate and was implemented as a task order in June 2021 due to missing hearing aid. Ms. Alt reported she was appointed the administrator in March 2021 and was not made aware of the lost hearing aid until May 2021 when Relative A1 requested reimbursement for the new hearing aid. Ms. Alt reported the family completed the complaint form and submitted it to the facility board of directors. Ms. Alt reported due to language in the admission contract and resident handbook it was determined the facility would not pay the family for the lost hearing aid. Ms. Alt reported the staff was re-trained on removing the hearing aid and placing in the locked medication cart. Ms. Alt reported Resident A is less combative with staff and staff are better trained in providing care to Resident A.

I reviewed Resident A's service plan. The service plan read,

> *"Hearing Aids. Keep in the cart at night as I allow. I also have a back up hearing aid. Staff to assist with hearing aid placement as needed, ensure hearing aide is turned on and in good working order, assist at HS with removal and proper storage as needed in med cart. Assist me to change my hearing aid batteries. Use the lubricant for placement."*

I reviewed chart notes for Resident A. The chart notes read,

> *"03/27/2021 HEARING AIDE: This resident is complaining that her hearing aide are not working. RN changed the battery and cleaned the hearing aides. The resident is still complaining she cannot hear. RN changed the battery again incase the battery was defective. Changing the battery twice did not make her hear any better. Will pass on to the next shift that her hearing aides should be sent into the hearing center to get checked if they are working or need to have the hearing adjusted.*
>
> *4/6/21: Writer received in verbal report resident inner ear on left side bleeding. 3rd shift med tech stated she cleaned her up and removed hearing aid. Writer entered room to admin medications this morning. Resident resting quietly in bed. Moderate amount dried blood observed to resident left ear, cheek and neck. Denied pain. On call med staff notified. NO changes at present. Will be in facility today to eval. Writer cleaned blood from neck and ear and gently flushed outer ear with warm water.*
>
> *04/09/2021: Resident continues antibiotic for ear. Small amount dried blood and serous drainage observed to outer ear this morning. Easily cleaned. No c/o pain. Hearing aid remains out.*
>
> *04/14/2021: Spoke with resident's daughter. She will be cancelling residents hearing aid appt today d/t missing hearing aid. LPN on Garden and this nurse went through all of resident's room, searching drawers, cups, tissue boxes,*

bed/bedding, etc. Hearing aid is nowhere to be found in room. Courtney, LPN states she last saw it when she locked it in the med cart last week. Since there was an order not to put hearing aid in, she did not look to see if it was still there until today when it was noted that it would be needed for resident's appt. (Relative A1) states res is very HOH and staff may need to write to her to communicate until found. Karen will reschedule appt at this time and we will continue to search and investigate for finding it.

4/14/21: Spoke with resident's daughter. She will be cancelling residents hearing aid appt today d/t missing hearing aid. LPN on Garden and this nurse went through all of resident's room, searching drawers, cups, tissue boxes, bed/bedding, etc. Hearing aid is nowhere to be found in room. Courtney, LPN states she last saw it when she locked it in the med cart last week. Since there was an order not to put hearing aid in, she did not look to see if it was still there until today when it was noted that it would be needed for resident's appt. (Relative A1) states res is very HOH and staff may need to write to her to communicate until found. (Relative A1) will reschedule appt at this time and we will continue to search and investigate for finding it.

05/04/2021: Missing Item Report completed for 2 right ear hearing aids. Forwarded to environmental services manager for completion of their portion and request for return."

I reviewed the medication administration record (MAR) for April 2021 for Resident A. The MAR revealed Resident A had an order that was dated 4/8 that read,

"cleanse external ear, ext auditory canal with gauze/ns dampened. BID two times a day for otitis media do not stick anything in ear."

I reviewed the admission contact signed by Resident A. The admission contract read,

"Pilgrim Manor will not be responsible for any Resident's valuables or money. Residents are encouraged to obtain Renters Insurance and not store valuables in their rooms. Pilgrim Manor has placed a locked safe keeping box in each room and we encourage residents to use this box if they prefer to keep to keep valuables in their room."

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: 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:	Resident A's hearing aids were lost at the facility. The facility attempted to locate the missing items by speaking with staff and searching Resident A's room. It is unknown what happened to her hearing aids. The staff made reasonable efforts to locate Resident A's items.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Ms. Alt reported once it was brought to her attention that the hearing aids were misplaced in the facility, it was determined to have the hearing aid removal placed on caregivers' task list. Ms. Alt reported this was implemented in June 2021. Ms. Alt reported by doing so it is easier to determine when an item is misplaced.

I reviewed the task list for June through December 2021. The task list read, "staff to help resident place (R) hearing aid in each AM and remove at HS. Hearing aid must be kept in med cart when not in use. The task list revealed multiple dates within each month this task was not completed.

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.

ANALYSIS:	The task list for Resident A revealed at nighttime caregivers are to remove the hearing aid and placed in the medication cart and then place back in Resident A's ear in the morning. The task list revealed multiple dates and times this task was not completed for Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 9/17/21, I conducted an exit conference with interim administrator Wendell Torrey by telephone after multiple attempts to exit conference with the authorized representative. Mr. Torry had no questions about the findings in this report.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the status of the license.

Kimberly Horst 8/26/21

Kimberly Horst Date
Licensing Staff

Approved By:

Russell Misiak 8/27/21

Russell B. Misiak Date
Area Manager