GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 22, 2021

LeeAnn Pennington
The Manor at Glacier Hills Home for the Aged
1200 Earhart
Ann Arbor, MI 48105

RE: License #: AH810236789
Investigation #: 2022A1021009
The Manor at Glacier Hills Home for the Aged

Dear Ms. Pennington:

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 (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 #:	AH810236789
Investigation #:	2022A1021009
Complaint Receipt Date:	11/19/2021
Investigation Initiation Date:	11/19/2021
Report Due Date:	1/19/2021
Licensee Name:	Glacier Hills Inc.
Licensee Address:	1200 Earhart Rd. Ann Arbor, MI 48105
Licensee Telephone #:	(734) 769-6410
Administrator:	Kathleen Butler
Authorized Representative:	LeeAnn Pennington
Name of Facility:	The Manor at Glacier Hills Home for the Aged
Facility Address:	1200 Earhart Ann Arbor, MI 48105
Facility Telephone #:	(734) 769-6410
Original Issuance Date:	09/11/2000
License Status:	REGULAR
Effective Date:	02/24/2021
Expiration Date:	02/23/2022
Capacity:	301
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Facility failed to provide medical attention.	No
Resident A's service plan not followed.	Yes
Resident A had unexplained weight loss.	Yes
Additional Findings	No

III. METHODOLOGY

11/19/2021	Special Investigation Intake 2022A1021009
11/19/2021	Special Investigation Initiated - Letter Referral sent to APS centralized intake
12/08/2021	Contact - Telephone call made Interviewed administrator
12/09/2021	Contact - Document Received Received documentation
12/16/2021	Contact-Telephone call made Interviewed nurse Kaneena Ali
12/22/2021	Exit Conference Exit Conference with authorized representative LeeAnn Pennington

The complainant identified some concerns that were not related to home for the aged licensing rules and statutes. 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.

ALLEGATION:

Facility failed to provide medical attention.

INVESTIGATION:

On 12/19/21, the licensing department received a complaint with allegations the facility failed to provide medical attention to Resident A. The complainant alleged Resident A complained of fatigue and shortness of breath The complainant alleged the family requested for tests to be run and the facility did not complete testing.

On 11/19/21, the allegations in this report were sent to centralized intake at Adult Protective Services (APS). APS determined they would not be investigating.

Due to the Covid-19 pandemic, this investigation was completed remotely.

On 12/8/21, I interviewed administrator Kathleen Butler by telephone. Ms. Butler reported Resident A was on a video call with his family and reported to them that he did not feel good and then laid on his couch. Ms. Butler reported family reported this to staff at the facility. Ms. Butler reported staff checked on Resident A who reported he felt fine and had no complaints of pain. Ms. Butler reported after that Resident A had a change in status and complained of not feeling well. Ms. Butler reported staff members called emergency medical services (EMS) and Resident A was transported to the hospital. Ms. Butler reported Resident A received the medical attention he required.

On 12/16/21, I interviewed nurse Kaneena Ali by telephone. Ms. Ali reported Resident A was sent out for a medical evaluation in November 2020 due to a change in condition. Ms. Ali reported a few days prior to his transfer, Resident A was seen by the physician. Ms. Ali reported the facility had completed lab work and vitals and the results were within normal range. Ms. Ali reported on the day he was sent out, she was notified by caregivers to assess Resident A. Ms. Ali reported Resident A's speech was slurred, he was unable to walk, and unable to dress himself. Ms. Ali reported it was determined Resident A required outside medical attention. Ms. Ali reported if a resident needs medical attention, the resident is sent out to the hospital. Ms. Ali reported the facility did everything correctly in regard to providing Resident A medical attention.

I reviewed Resident A's clinical notes. The notes read,

"10/7: Continues to have bad dreams. He states he is not brushing his teeth because he lost his toothbrush recently. He is unable to tell me his age. He states he walks the court for exercise. He wakes hungry he denies pain, shortness of breath or coughing.
11/24: Family notified staff that during zoom visit resident reported a sharp stabbing pain in chest. Resident stated, "I laid down a bit and it went away." No c/o pain at this time. Family wanted staff to make a note. Resident is currently sitting in room on sofa.
11/25: SpO2 98%

11/25: Nurse notified resident had unsteady gait unable to walk. V/S obtain BP: 128/94, P: 114, T: 97.5, ox 93% RA. Resident states "I feel unlike myself." Unable to keep eyes open speech mumbled. Color is gray and cool to touch. Labored breathing. MD and family notified. New order to send resident to St. Joes ED for eval acute states change. Resident with HVA at 11:30am family will meet resident at hospital."

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: **(c) Assure the availability of emergency medical care required by a resident.**
ANALYSIS:	Review of chart documentation and interviews with staff revealed Resident A had a change in condition that required medical attention. The facility acted in a timely manner to provide medical attention to Resident A.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A's service plan not followed.

INVESTIGATION:

The complainant alleged Resident A did not have his hearing aids charged and inserted daily, glasses available to him, assistance with meals, laundry completed, and other personal hygiene tasks completed. The complainant alleged Resident A's room was very dirty.

Ms. Butler reported caregivers were to ensure Resident A had his hearing aids in, but often he would take them out and place them in his room. Ms. Butler reported caregivers assisted Resident A with hygiene tasks. Ms. Butler reported the facility has housekeeping staff that are responsible for cleaning resident rooms once a week. Ms. Butler reported laundry is also done once a week or more if needed. Ms. Butler reported these tasks were completed according to Resident A's service plan.

I reviewed Resident A's service plan. The service plan read,
Hearing Aids-Yes
Vision-Glasses-Yes

Family or GH (Glacier Hills) Laundry- GH services
Housekeeping needs: Bed change every Wednesday; GH Services

I reviewed Resident A's clinical notes documentation. The documentation read, *"11/26: Hearing aids are missing, resident keeps them in room, often takes them out and misplaces them.*

I reviewed September 2020 medication administration record (MAR) for Resident A. The MAR read,

"Assist resident to place hearing aids in charger at bedtime on dresser beside bed."

The MAR revealed this was not completed on 9/3-9/5, 9/10-912, 9/20, 9/22-9/23, 9/25, and 9/27-9/30.

"Check hearing aids at AM and "before bed."

The MAR revealed this order was stared on 9/22. This was not completed in the AM on 9/24, 9/26-9/27, and 9/30. This was not completed in the evening on 9/23, 9/25, and 9/28-9/29.

Similar findings were noted with October and November 2020 MAR.

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.
Reference: R325.1901	**Definitions.**
	(21) "Service plan" means a written statement prepared by the home in cooperation with a resident and/or the resident's authorized representative or agency responsible for a resident's placement, if any, and that identifies the specific care and maintenance, services, and resident activities appropriate for each 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's MAR had specific instructions regarding the hearing aids, but the service plan was not inadequately

	developed to include care tasks for caregivers to complete. Therefore, important care tasks were not completed. In addition, review of Resident A's service plan revealed lack of detail regarding his specific needs. For instance, his plan identified he had glasses and wore hearing aids. However, it is not known where these devices were kept, if he required a staff member to assist him, and the level of staff member assistance needed. Due to the staff changes and extended length of time that Resident A has been at the facility, it is unable to be determined if Resident A had his hearing aids at the facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A had unexplained weight loss.

INVESTIGATION:

The complainant alleged Resident A lost 20 pounds between September to November 2020. The complainant alleged caregivers would deliver food to Resident A's room but would not assist him with eating. The complainant alleged Resident A had a companion that would assist him with eating. When the facility shut down visitation due to a Covid-19 outbreak, the companion was no longer allowed in the facility. The complainant alleged Resident A's family and companion were not notified when the ban on visitation was lifted.

Ms. Butler reported the facility held care conferences with Resident A's family and discussed increasing dietary supplements to assist with the weight loss. Ms. Butler reported Resident A was seen by the facility physician once every three months. Ms. Butler reported if a concern arises about a resident, the resident can be seen by the facility physician. Ms. Butler reported the facility shut down visitation due to a Covid-19 outbreak. Ms. Butler reported all residents and family members were notified of this. Ms. Butler reported when the facility re-open visitation residents and family members were notified.

Resident A's service plan read,

"Set-Up & Tray delivery when needed, encourage meals.
Resident has depression, encourage resident to eat meals and provide zoom calls to his family."

I reviewed Resident A's clinical notes. The notes read,

"Cheryl Huckins, MD 10/07: Prune juice daily. Increase Citracel to 2 tabs po daily. Bedtime snack. Ensure daily. Pt needs essential caregiver to remind him to eat. D/C Ensure Start Boost BID
10/07: Weight 148.5 pounds which is down 7 pounds. Weight loss-discussed with his son. Will increase boost to twice daily. If weight loss continues may need to consider hospice.
11/23: New orders Mirtazapine 7.5mg po Q HS CMP, CBC, Pre albumin in am, UA encourage resident to brush teeth. Encourage ensure to TID. Allow daily companion to visit and encourage eating.
11/26: phone conference held by writer with daughter and son. Writer discussed observation of resident status. Moderate cognitive impairment, needs max cueing for meals which staff and writer have been assisting with. Writer has seen resident with ensure and full hydration glasses in room with encouragement by staff to drink. Resident does continue to loss weight. Discussed interventions with family ie short list for higher acuity assistance level. In the meantime, family agreeable to initiating having resident additional caregiver come in for support. Discussed above with MD who was seeing resident in clinic today with family present via facetime."

I reviewed September MAR. The MAR read,

"Boost Energy Drink. Give 237ml by mouth once daily."
The MAR revealed this was completed 9/1-9/30.

"Weigh weekly on Fridays."
On 9/4 this was not completed. On 9/11, Resident A's weight was 142. On 9/18, weight 142 and 9/25 weight was 143.

"HS (bedtime) snack."
This was not completed on 9/1, 9/5, 9/10-9/12, 9/22-9/23, 9/25, 9/27-9/29.

I reviewed October MAR. The MAR read,
Boost Energy Drink. Give 237ml by mouth once daily."
This was not completed on 10/28 and 10/30.

"Weigh weekly on Fridays."
On 10/2, Resident A's weight was 142. On 10/7, Resident A's weight was 142. On 10/9, Resident A's weight was 144. On 10/16, Resident A's weight was 146. It was not completed on 10/23 and 10/30.

"HS snack."
This was not completed on 10/2, 10/5, 10/17-10/18, 10/24, 10/26-10/27,

I reviewed the November MAR. The MAR read,

"Boost 1 bottle BID (two times a day) 10/7/20.

This was be done at 8am and 5pm. This was not done at 5pm on 10/17-10/18 and 10/25-10/26.

This was not done at 8am on 10/12, 10/28, and 10/30.

"Boost Energy Drink. Give 237ml by mouth twice daily."

It was discontinued on 11/23. This was not completed at 9am on 11/6.

This was not completed at 5pm on 11/5, 11/17, 11/20, and 11/23-11/24.

"Weigh weekly on Fridays."

This was not completed on 11/6 and 11/16. On 11/20, Resident A's weight was 139.

"HS snack."

This was not provided on 11/5, 11/17, and 11/20.

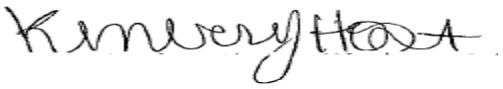
APPLICABLE RULE	
R 325.1951	**Nutritional need of residents**
	A home shall meet the food and nutritional needs of a resident in accordance with the recommended daily dietary allowances of the food and nutrition board of the national research council of the national academy of sciences, adjusted for age, gender, and activity, or other national authority acceptable to the department, except as ordered by a licensed health care professional
ANALYSIS:	Due to the staff changes and extended length of time that Resident A has been at the facility, it is unable to be determined the timeline of events with the companion assisting Resident A with eating. However, upon chart review it was determined that Resident A was having a difficult time eating and was having weight loss. In October 2020, Resident A's physician recommended for Resident A to have an essential caregiver assist Resident A with eating and supplements were added to Resident A's diet. Review of Resident A's service plan revealed caregivers were to "encourage" Resident A to eat. It is not known the level of assistance Resident A required with eating. In addition, review of September-November 2020 MAR revealed Resident A was to have a Boost drink, bedtime snack, and was to be weighted. However, there was multiple dates with each

	order that Resident A did not receive the necessary supplements.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 12/22/21, I conducted an exit conference with authorized representative LeeAnn Pennington by telephone.

IV. RECOMMENDATION

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



12/16/2021

Kimberly Horst Date
Licensing Staff

Approved By:

12/22/2021

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