GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

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

October 23, 2023

RE: License #: AH250356639
Investigation #: 2023A1022050
McFarlan Home

Dear Kahlia Harper:

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.

Please review the enclosed documentation for accuracy and contact me with any questions.

Sincerely,

Barbara P. Zabitz, R.D.N., M.Ed.
Health Care Surveyor
Health Facility Licensing, Permits, and Support Division
Bureau of Community and Health Systems
Department of Licensing and Regulatory Affairs
Mobile Phone: 313-296-5731
Email: zabitzb@michigan.gov

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH250356639
Investigation #:	2023A1022050
Complaint Receipt Date:	08/21/2023
Investigation Initiation Date:	08/22/2023
Report Due Date:	10/20/2023
Licensee Name:	McFarlan Kearsley Residence, LLC
Licensee Address:	700 Kearsley St. Flint, MI 48503
Licensee Telephone #:	(810) 252-8684
Authorized Representative/Administrator	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:	11/30/2022
Expiration Date:	11/29/2023
Capacity:	29
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
The Resident of Concern (ROC) did not receive the assistance she needed for toilet use and incontinence.	Yes
The ROC was given food and beverage that caused her blood sugar to be out of control.	Yes
The ROC was mistreated after being discharged from the facility.	Yes
Additional Findings	Yes

III. METHODOLOGY

08/21/2023	Special Investigation Intake 2023A1022050
08/22/2023	Special Investigation Initiated - Telephone Complainant interviewed by phone.
08/29/2023	APS Referral
08/29/2023	Inspection Completed On-site
10/23/2023	Exit Conference

ALLEGATION:

The Resident of Concern (ROC) did not receive the assistance she needed for toilet use and incontinence.

INVESTIGATION:

On 08/17/2023, the complainant called the Bureau of Community and Health Systems (BCHS) complainant hotline with allegations regarding her mother, the Resident of Concern (ROC). According to the intake unit's interview, "[Name of the ROC] started living at the facility 12/21/2022 and the next day the caller (the complainant) came to visit and overhear the staff saying how bad the 3rd shift had neglected the resident's care. The resident was left in a soiled bed… The caller noticed while doing the laundry that the resident had been going (urinating and defecating) in her clothes which lead the caller to believe that facility was continuing to not change the resident enough."

On 08/22/2023, I interviewed the complainant by phone. The complainant stated that it was her belief that the ROC was not receiving the proper assistance with toilet use, especially on the overnight shift.

On 08/29/2023, a referral was sent to Adult Protective Services.

On 08/29/2023, at the time of the onsite visit, I interviewed the newly hired administrator/authorized representative (AR) and outgoing administrator. The outgoing administrator stated that her last day at the facility was Friday, 09/01/2023 and the newly hired AR would be taking over the duties of the administrator, at least temporarily. I asked if any of the facility's residents were still in their beds prior to receiving their morning care. The administrator identified Resident A and Resident B and asked the resident care supervisor to accompany me while I made observations.

Resident A was lying in bed, with the bedspread pulled up to her mid-body. She was alert and able to engage in conversation but was confused. The resident care supervisor identified Resident A as "total care" for toilet use and incontinence. When the resident care supervisor uncovered Resident A and loosened her incontinence brief, the brief was saturated with urine and soiled with feces. The resident care supervisor stated that the overnight caregiver should have given Resident A incontinence care prior to the end of the shift; however, it was clear that did not happen. The pad underneath Resident A was soaked with urine and feces as were the bed linens on her bed.

When I got to the room occupied by Resident B, the caregiver was just helping her on with her pants. All care had been provided.

According to her service plan, the ROC need assistance with the bathroom and with managing “protective garment change(s).” According to the caregivers’ assignment sheet, she was to be “check(ed) and change(d) every two hours.” According to Resident A’s service plan, she had “chronic unmanaged incontinence,” and was to be checked every 2 hours and as needed.

When the outgoing administrator was asked to describe what kinds of documentation was available to provide evidence that a resident had received care as scheduled on their respective service plan, the outgoing administrator stated that the only documentation would be the caregivers’ assignment sheet. Review of facility assignment sheet for July 2023 revealed that caregivers used the assignment sheets to acknowledge their daily responsibilities but did not document that care had been delivered.

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:	The allegation was substantiated. Direct observation indicated that Resident A did not receive adequate incontinence care. There was no evidence the ROC received adequate assistance with incontinence or toileting.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The ROC was given food and beverage that caused her blood sugar to be out of control.

INVESTIGATION:

According to the intake unit’s interview, “the facility is constantly giving the resident sugar while knowing that the resident has type 2 diabetes. This has led to multiple instances where the residents blood sugar was too high and had to be taken to the ER. The facility has also given the resident to much insulin which made the resident dazed and had to go to the ER.”

When interviewed, the complainant described how staff members were always giving the ROC food items with a high sugar content and large amounts of fruit juice. According to the complainant, she also had diabetes and had been instructed to limit the amount of fruit juice she drank to help control her blood sugar levels.

According to her service plan, the ROC diet was described as “NCS,” that is, no added sweets.

When asked about care provided to residents with diabetes, the outgoing administrator stated that the facility caregivers would follow the orders provided by the healthcare provider. Neither the outgoing administrator or the newly hired AR were able to describe any instructions given to caregivers regarding food and beverage selections for residents were to receive diets described as NCS. When asked about the ROC, the outgoing administrator stated that the family had voiced their disapproval of giving the ROC juices and other food items that were high in sugar content. After becoming aware of the family’s opinion, they stopped giving the ROC those types of items. The facility was not able to provide any policies, guidelines, instructions, or protocols that helped caregivers know what food and beverage items might be modified for residents who were to be on NCS diets, the AR acknowledged caregivers were not provided guidance for that.

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(2) 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:	The facility had not established what foods and beverages could safely be consumed by residents with a diet order for NCS and which items should be limited.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The ROC was mistreated after being discharged from the facility.

INVESTIGATION:

According to the intake unit's interview, "the caller decided to move her mother out of the facility. The new facility then came to collect her mother's things and bed but was not able to take the resident to a new facility. So, McFarlan Home let the resident sleep in the wheelchair overnight instead of contacting the resident family and letting them know that there wasn't a bed for the resident to sleep on."

According to the complainant, the ROC had been discharged from the McFarlan Home before a room was ready for her at the new facility. The ROC, who was a hospice/home care patient, had been sleeping in a hospital bed provided by the hospice/home care. After being discharged from the facility, the hospice/home care agency removed the hospital bed from the facility, leaving the ROC without a bed. The complainant went on to say that the facility staff did not try to call her or the ROC's husband to come to get the ROC, or to even assist her into a recliner chair or couch but made her sit in a wheelchair overnight.

When asked about the ROC's departure from the facility, the outgoing administrator stated that there had been some friction with ROC's family member, who decided that the ROC should be placed in another facility. The outgoing administrator stated that the family member was to pick up the ROC before 2 pm on the day the hospice removed the bed, but never showed up. The hospice agency came to the facility and picked up the bed. The outgoing administrator stated that she called the ROC's husband regarding the ROC and the husband stated he would contact the family member and remind her that the ROC was waiting for her. The outgoing administrator acknowledged that she had not called the family member, because she was not to have any contact with the family member. When asked if she had requested someone else call the family member, the outgoing administrator acknowledged that she had not. She stated that she did not know whether or not the ROC slept in a wheelchair on the day. There was no documentation of the event.

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(3) 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:	There was no evidence to contradict the complainant's allegations. However, it was clear that the bed that the resident was utilizing was removed prior to the resident relocating to the new facility.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

According to the complainant, the ROC had to spend her last night in the facility seated in her wheelchair. The outgoing administrator stated that the ROC's family member had been expected to come to the facility to transport the ROC to her new residence, but never came. Both the outgoing administrator and the AR were asked if there had been any documentation that regarding the ROC's last hours at the facility. According to the AR, no documentation had been kept.

APPLICABLE RULE	
MCL 333.20175	**Maintaining record for each patient; wrongfully altering or destroying records; noncompliance; fine; licensing and certification records as public records; confidentiality; disclosure; report or notice of disciplinary action; information provided in report; nature and use of certain records, data, and knowledge.**
	(1) A health facility or agency shall keep and maintain a record for each patient, including a full and complete record of tests and examinations performed, observations made, treatments provided, and in the case of a hospital, the purpose of hospitalization.
ANALYSIS:	The facility did not record observations made of the ROC as she waited to transportation to her new residence.
CONCLUSION:	**VIOLATION ESTABLISHED**

I reviewed the findings of this investigation with the authorized representative (AR) and the corporate compliance officer on 10/23/2023. When asked if there were any comments or concerns with the investigation, the AR stated that there were none.

IV. RECOMMENDATION

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

10/23/2023

_____

Barbara Zabitz Date
Licensing Staff

Approved By:

10/18/2023

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