GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

November 14, 2024

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

RE: License #: AH810236789
Investigation #: 2025A1027007
The Manor at Glacier Hills Home for the Aged

Dear Licensee:

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 877-458-2757.

Sincerely,

Jessica Rogers, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 285-7433
enclosure

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

## I. IDENTIFYING INFORMATION

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|---|---|
| **License #:** | AH810236789 |
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| **Investigation #:** | 2025A1027007 |
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| **Complaint Receipt Date:** | 10/29/2024 |
| | |
| **Investigation Initiation Date:** | 10/29/2024 |
| | |
| **Report Due Date:** | 12/28/2024 |
| | |
| **Licensee Name:** | Glacier Hills Inc. |
| | |
| **Licensee Address:** | 1200 Earhart Rd.<br>Ann Arbor, MI 48105 |
| | |
| **Licensee Telephone #:** | (734) 769-6410 |
| | |
| **Administrator:** | LeAnn Pennington |
| | |
| **Authorized Representative:** | Benjamin McKinnon |
| | |
| **Name of Facility:** | The Manor at Glacier Hills Home for the Aged |
| | |
| **Facility Address:** | 1200 Earhart<br>Ann Arbor, MI 48105 |
| | |
| **Facility Telephone #:** | (734) 769-6410 |
| | |
| **Original Issuance Date:** | 09/11/2000 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 08/01/2024 |
| | |
| **Expiration Date:** | 07/31/2025 |
| | |
| **Capacity:** | 116 |
| | |
| **Program Type:** | AGED |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Resident A was neglected. | Yes |
| Poor meals were served. | No |
| Additional Findings | No |

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

## III. METHODOLOGY

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| 10/29/2024 | Special Investigation Intake<br>2025A1027007 |
| 10/29/2024 | Special Investigation Initiated - Letter<br>Email sent to AR Ben Mckinnon, Administrator Leann Pennington, and Kat Butler to obtain additional information pertaining to Resident A |
| 10/30/2024 | Contact - Document Received<br>Email received from Kat Butler with requested information |
| 11/06/2024 | Inspection Completed On-site |
| 11/08/2024 | Inspection Completed-BCAL Sub. Compliance |
| 11/14/2024 | Exit Conference<br>Conducted by email with Ben McKinnon and LeAnn Pennington |

**ALLEGATION:**

**Resident A was neglected.**

**INVESTIGATION:**

On 10/29/2024, the Department received an online complaint alleging that, despite discussions with staff regarding Resident A's care needs, the resident became malnourished and weak. The complaint read that Resident A did not receive physical

and occupational therapy (PT/OT). Additionally, the complainant contacted staff multiple times about Resident A's worsening pain and declining health. According to the complaint, Resident A was eventually transferred to the hospital, where the physician determined she was neglected. The complaint also notes that Resident A passed away on 9/18/2023. Additionally, it was alleged that Resident A was never evaluated for infection and should have been sent to the hospital earlier. The complainant asserted that with proper care, Resident A's life could have been prolonged.

On 11/6/2024, I conducted an on-site inspection and interviewed staff.

Employee #1 stated that Resident A was admitted to the skilled nursing facility for a short-term stay, transferred to the hospital, and then moved to the Home for the Aged (HFA) on 7/31/2023. Employee #1 confirmed that Resident A had a few emergency visits during her stay, and physician orders, including pain medication recommendations, were followed. Resident A was treated for abdominal pain and gout and was prescribed Lyrica for pain. Additionally, Employee #1 noted that Resident A was diagnosed with left hand cellulitis and treated with antibiotics during a hospitalization.

Employee #1 explained that activities of daily living (ADL) records could not be pulled into the system due to their age. However, there were no chart notes indicating that Resident A missed any scheduled showers. Employee #1 also stated that staff charted by exception, meaning they would document in the chart if a resident declined a shower or if a shower was not provided for another reason.

Additionally, Employee #1 reached out to Resident A's physician's office to request the dates of her appointments and to provide a timeline of events from admission to discharge. The timeline read in part Resident A went to the hospital for severe pain in her left hand/arm on 8/19/2023 and returned on 8/21/2023. The timeline read Resident A admitted to Dr. Sarafa's services on 8/16/2023 but due to hospitalization, her first appointment with the nurse practitioner was 8/25/2023 to address her stomach pain and incontinence. Resident A was evaluated by the nurse practitioner on 9/1/2023.

Resident A's face sheet read consistent with the information provided by Employee #1. It noted that Resident A was sent to the hospital on 9/13/2023 for renal failure, and her family elected hospice care instead of dialysis. Resident A passed away at the hospital.

Resident A's service plan, updated on 8/2/2023, was reviewed with Resident A's relative (Relative A1) both in person on 7/28/2023 and by telephone on 8/2/2023. The plan included instructions for Resident A to receive showers twice weekly, on Tuesdays and Saturdays, and noted that she required a Hoyer lift and two-

person assistance for transfers. The plan also included an area for meal preferences, though it lacked specific details.

Resident A's chart notes from 7/31/2023 to 9/13/2023 were consistent with the statements made by Employee #1. Key chart notes included:

8/6/2023: Resident A requested her as-needed Oxycodone, but it had been discontinued. Her scheduled Tylenol was administered instead.

8/10/2023: Resident A complained of stomach pain and requested to go to the hospital or see her doctor.

8/15/2023: Resident A complained of left arm pain and wanted to go to the hospital.

8/18/2023: Resident A requested to go to the emergency room.

8/19/2023: Resident A complained of hand pain, which was observed to be swollen and red. Her family requested she be transferred to the hospital, and she was picked up by ambulance at 5:45 PM.

8/21/2023: Resident A went to a medical appointment.

8/22/2023: PT/OT referrals were received on 8/21/2023 and Resident A's screening was completed. The note read speech therapy was requested to have her diet upgraded.

8/25/2023 & 8/27/2023: Resident A had diarrhea, and Imodium was administered on 8/27/2023.

8/29/2023: Resident A reported pain and requested to go to the hospital.

9/4/2023: Resident A had a change in condition with diarrhea occurring four times within one hour.

9/5/2023: A referral for speech therapy was requested from her physician.

9/7/2023: Resident A exhibited multiple incidents of diarrhea and confusion, prompting staff to notify the nurse manager, nurse supervisor, durable power of attorney, and primary care physician. Resident A was sent to the emergency department by ambulance.

9/13/2023: Resident A was discharged to the hospital with kidney failure.

I also reviewed the facility's Grievance/Complaint Reports for Resident A:

8/6/2023: A report noted that Resident A was upset because her Oxycodone prescription, ordered for only seven days by the University of Michigan hospital, had run out. Dr. Alford declined to renew the prescription, and staff were instructed to continue administering scheduled Tylenol.

8/23/2023: A report noted Resident A's complaints of abdominal pain and incontinence. The nurse practitioner prescribed medications for diarrhea, gout, and loss of bladder control.

8/29/2023 & 8/30/2023: Reports indicated that Resident A requested stronger pain medication than Tylenol, and although the nurse practitioner was notified, no new orders were received, even after a second request.

8/31/2023: A report noted that Resident A requested stronger pain medication, and the nurse practitioner ordered Lyrica to be administered three times daily as needed for pain.

I reviewed Resident A's medication administration records (MARs) for July, August, and September 2023. The July 2023 MAR confirmed the Oxycodone prescription was for severe pain up to seven days, as well as medications prescribed for diarrhea, gout, and loss of bladder control.

I reviewed the facility's incident report dated 9/7/2023, which was consistent with the chart notes for that day. The report noted that Resident A's service plan would be updated to encourage increased fluid intake.

| **APPLICABLE RULE** | |
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| **R 325.1921** | **Governing bodies, administrators, and supervisors.** |
| | **(1) The owner, operator, and governing body of a home shall do all of the following:**<br><br>**(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: 333.20201** | **Policy describing rights and responsibilities of patients or residents; adoption; posting; contents; additional requirements; discharging, harassing, retaliating, or discriminating against patient exercising protected right; exercise of rights by patient's representative; informing patient or resident of policy; designation of person to exercise rights and responsibilities; additional patients' rights; definitions** |
| | **(d) A nursing home patient or home for the aged resident is entitled to the opportunity to participate in the planning of his or her medical treatment. The attending physician, a physician's assistant with whom the physician has a practice agreement, or an advanced practice registered nurse, shall fully inform the nursing** |

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| | **home patient of the patient's medical condition unless medically contraindicated as documented in the medical record by a physician, a physician's assistant with whom the physician has a practice agreement, or an advanced practice registered nurse. Each nursing home patient shall be afforded the opportunity to discharge himself or herself from the nursing home.** |
| **ANALYSIS:** | The facility's documentation, including chart notes, grievance reports, and medication records, generally aligned with the statements provided by Employee #1. The records show that staff contacted Resident A's physician regarding her requests for pain medication, and orders were implemented as received. However, it was unclear why therapy service orders were not received until 8/21/2023, several weeks after her move-in date.<br><br>Nonetheless, chart notes from 8/10/2023, 8/15/2023, and 8/18/2023 indicate that Resident A complained of pain and requested to go to the hospital or see her doctor, then she was transferred to the hospital on 8/19/2023 for cellulitis.<br><br>Further chart notes dated 8/29/2023 document Resident A reported pain again, and the timeline indicates she was evaluated by the nurse practitioner on 9/1/2023; however, chart note on 9/4/2023 documents a change in condition due to diarrhea, with Resident A being sent to the emergency room on 9/7/2023 after multiple incidents of diarrhea and confusion.<br><br>Given that the documentation indicated that Resident A repeatedly requested medical treatment prior to her transfers, this part of the allegation was substantiated due to a lack of timely medical treatment. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**ALLEGATION:**

**Poor meals were served.**

**INVESTIGATION:**

On 10/29/2024, the Department received allegations through the online complaint system which read despite discussions with staff about Resident A's dietary preferences, the facility provided poor meals.

On 11/6/2024, I conducted an on-site inspection and interviewed staff.

Employee #1 explained that residents' dietary preferences were collected upon admission, and their diets were prescribed by their physician. Residents could return their meals anytime if they were dissatisfied and request a different item. Each resident had the option to choose items from the alternative menu. Additionally, water or the resident's beverage of choice was offered by staff during each shift and at mealtimes, with beverages available upon request throughout the day. Employee #1 further stated that the facility received positive feedback regarding the quality of the food.

Employee #1 noted that Resident A had not complained about the food or expressed any specific dietary preferences, which would have been documented in her service plan. Employee #1 also confirmed that Resident A was prescribed a regular diet with nectar-thick liquids and, as such, had the option to request any food she preferred.

Administrator LeAnn Pennington confirmed that she had not received any complaints about the food.

Resident A's service plan, last updated on 8/2/2023, was consistent with the information provided by Employee #1.

I reviewed the facility's 4-week menu, which offered a variety of nutritious options, including a daily soup selection. The alternative menu provided several choices, such as soups, deli sandwiches, entrees (e.g., hamburgers, grilled cheese, chicken breast), side dishes (e.g., salads, vegetables, cottage cheese), drink options, and snacks. The menu also included the statement: "*Our goal is to ensure an excellent dining experience. Please notify staff of any issues with your meals*."

Resident A's chart notes, dated 7/31/2023 to 9/13/2023, were consistent with Employee #1's statements and indicated that as of 7/31/2023, Resident A was on a regular diet with nectar-thick liquids.

| **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.** |

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| **ANALYSIS:** | The facility maintains a variety of meal options, including an alternative menu, and actively encourages feedback from residents regarding their dining experience. Resident A's service plan was in line with the prescribed diet and there were no documented complaints or concerns about the food. Additionally, staff confirmed that Resident A had not expressed dissatisfaction with meals. There was lack of evidence to support the claim of poor meals being served to Resident A; therefore, this allegation was unsubstantiated. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

## IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of this license remain unchanged.

Jessica Rogers

11/13/2024

Jessica Rogers Date
Licensing Staff

Approved By:

Andrea L. Moore

11/13/2024

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