GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
MICHIGAN VETERAN HOMES
LANSING

ANNE ZERBE
EXECUTIVE DIRECTOR

June 24, 2020

Governor Gretchen Whitmer
State of Michigan
Romney Building
Lansing, MI 48909

Dear Governor,

SUBJECT: PA 314 of 2016 – FY ’20 First Quarter Reporting

Attached please find the quarterly report from the D.J. Jacobetti Home for Veterans and the Grand Rapids Home for Veterans, pursuant to Public Act 314 of 2016, MCL 36.9.

If you have any questions regarding this report, please contact Fred Schaible at 517.243.2147.

Sincerely,

Anne Zerbe
Executive Director, MVH

Attachment

cc: Tom Barrett, Senate Appropriations Subcommittee on DMVA Chair
Dr. John Bizon, Senate Families, Seniors and Veterans Committee Chair
Beau LaFave, House Military, Veterans and Homeland Security Committee Chair
Aaron Miller, House Appropriations Subcommittee on Military and Veterans Affairs Chair
MG Paul Rogers, DMVA Director

Pursuant to Public Act 152 of 1885 (as amended by PA 314 of 2016), MCL 36.9:

Sec. 9 (1) No later than January 1, April 1, July 1, and October 1 of each year, the Michigan Veteran Homes, its successor agency, or the Department of Military and Veterans Affairs shall report in writing all of the following information concerning any state veterans' facility to the governor, the senate and house committees on veterans affairs, and the senate and house appropriations subcommittees for the Department of Military and Veterans Affairs:

(a) Staffing levels and the extent to which staffing levels do or do not meet industry standards.

38 CFR Part 51.130(d) requires a minimum of 2.5 hours per-patient delivered (PPD). Actual total direct care PPD:

FY 20 Q1:
DJJH - 3.87
GRHV - 4.70

(b) Number of patient complaints, average time to review a complaint and respond, and response to each complaint.

FY 20 Q1:

DJJHV - (6) Complaint forms submitted - all complaints resolved within policy required time allotment.

1. **Concern:** On 10/9/19, a member's wife complained that her husband's shirts came back from the laundry and were wrinkled; the shirts are sometimes put into a drawer instead of hung up as they should be. She also was concerned that sometimes when she arrives in the morning, her husband has not yet been shaven or had his hair combed.

   Facility Response: The wife's concerns were reviewed with housekeeping staff, who deliver member laundry to member rooms, as well as nursing. Staff was reminded to hang shirts in member closets, ensure the member has his hair combed, and is shaven as soon as possible in the morning. The RN supervisor followed up to ensure these concerns are addressed.

2. **Concern:** On 10/31/19, member complained that he did not have enough cigarettes in the cigarette locker. He claimed that one package of cigarettes was missing.

   Facility Response: There were three cigarettes remaining in a pack in the smoking locker. An investigation revealed that the member's guardian brought in three packs of cigarettes for the member on 10/26/19. Interviews with staff who supervise smoking indicated that the member smokes many cigarettes during each smoking time, and it is reasonable that he could have smoked three packs in five days. The guardian was notified that more cigarettes were needed for the member; the situation was resolved 11/04/19.

3. **Concern:** On 11/11/19, a member was concerned because he was left at the dialysis provider for 1.5 hours after he had completed his dialysis run. The member stated that he tried numerous times to call the runner to pick him up, but no one answered the telephone line. As a result, the member missed the Veteran's Day Ceremony at the Home.

   Facility Response: Due to the Veteran's Day holiday, there were no transporters working that day. Nursing staff had transported the member to dialysis. The phone number that the member was dialing was a line to the transporter's phone; thus, no one answered the calls. Upon return to the Home, the member was immediately provided the Home supervisor's cell phone number; this phone is always carried by the supervisor on duty, 24 hours per day. On 11/12/19, an apology was given to the member by the Director of Nursing; the member accepted the apology. Note - this type of incident is clearly something we would never want to have happen again.

4. **Concern:** On 11/13/19, a member's son verbalized multiple complaints related to his father's recent room move. His first complaint was that the son had not been asked about the room move prior to completion. He also noted that his father's telephone in his room was not working. When he visited, he found that his father's clothing items had not been put away; rather, his clothing items had been stacked on top of his personal items and subsequently covered with bedding. He was concerned that his father can no longer straighten his room or put his clothing away; he believes that staff should be putting the clothing items away.

   Facility Response: The phone was immediately checked by staff and found to be unplugged. When the phone was plugged in, it began working properly. On 11/13/19, the Director of Nursing spoke with the son regarding the complaints. Review of documentation related to the room move revealed that the member, as his own decision maker, had agreed with the move to another room. The son was notified of the move after it was completed but not in advance of the move. The son indicated that sometimes he can be helpful in coordinating these things better with his dad and asked to be involved more on the front end in the future. The son was also informed that the member does not like to have staff put away his belongings because he feels they do not do things the way he would like to have them done. The son suggested giving his father control by having him assist in labeling the drawers for placement of clothing items or deciding on a central place to put clothing so his father can put items away himself. This information was provided to the Nurse Manager on the unit where the member resides.

5. **Concern:** On 11/18/19, there was a complaint from a member's wife that the members' meal trays in the 1N Dayroom were late for the lunch meal. She stated the meal is normally served at 1145-1150, and the trays did not arrive to the unit until the dietary supervisor delivered the cart at 1245. The manager did not apologize for the delay. Nursing staff indicated to the family that they had attempted to call the kitchen but there was no answer to the call.

   Facility Response: The dietary manager immediately responded that the 1N trays were accidentally loaded into the 2S cart. The 2S nursing unit notified the kitchen as soon as the error was noticed, and the carts were reloaded and delivered to the proper location. The dietary manager apologized to all present for the error at the time of the incident.

6. **Concern:** On 11/25/19, a member's daughter verbalized a concern that the medical provider is discussing a medical procedure with the member and not with his family. The family does not believe that the member understands and cannot make medical decisions for himself.

   Facility Response: The member was evaluated by the medical director on 11/26/19 and found that the member, by her evaluation, could make his own medical decisions. The member did express that he would like his family to also be involved with decisions. This request will be honored; the daughter was updated accordingly.

GRHV – (11) Complaint forms submitted - all complaints resolved within policy required time allotment (average 5 days).

1. **Concern:** On 10/2/19, five concerns were received from members regarding the disposal of pop cans and bottles.

   Facility Response: Members who filed the concerns were refunded the amount of money they claim they would have received if the containers had been returned. These members were also re-educated regarding the necessity of keeping a clean environment; a reminder was issued by the Home staff to members.

2. **Concern:** On 10/14/19, a member expressed concern that another member was cursing/swearing loudly near the elevator.

   Facility Response: The member's behavior was addressed by staff and a behavior contract was completed.

3. **Concern**: On 10/15/19, a caregiver alleged that a member had not received care according to the plan.

   Facility Response: Video was reviewed by staff which showed that care was indeed provided to the member by another caregiver.

4. **Concern:** On 10/30/19, a member expressed concern that business office personnel were responding with a "heavy hand" regarding the need to adhere to board policy and personal assets.

   Facility Response: The administrator met with the member, and the member stated that he was satisfied with the resolution.

5. **Concern:** On 11/12/19, a volunteer was observed shaking his fist at a member from the Memory Unit.

   Facility Response: An investigation commenced, and the volunteer was suspended, pending review of investigation. It was determined that the volunteer did shake his fist at a member; however, there was no intention of intimidation. The member shook his fist at the volunteer initially, and the volunteer was mirroring the member's behavior. An extensive one-day orientation was provided to the volunteer and the volunteer expressed understanding; the volunteer returned to volunteer status.

6. **Concern:** On 11/25/19, it was alleged that staff had slow response times to call lights.

   Facility Response: Video was reviewed by staff and response times were actually 1.5 minutes. Staff spoke with the member and family regarding the video results and the member expressed no further concerns.

7. **Concern:** On 11/26/19, a member was left behind in a store on a shopping trip.

   Facility response: An investigation revealed that one employee was responsible for ensuring a proper head count; however, the employee failed to do so. The staff member was formally addressed regarding the incident.

8. **Concern:** On 12/6/19, a member complained that alternate activities were being set up too early in the dining room, and he believed he was rushed to finish his meal.

   Facility Response: The volunteer group conducting the alternate activities was re-educated regarding the Kozy Korner dining room etiquette.

9. **Concern:** During Member Council on 12/6/19, two members stated that the call lights are being answered in a timely manner, but then staff turn the lights out and return later to attend to the member.

   Facility Response: Call light studies (audits) were completed, and it was determined that the average wait time was 1.5 minutes. Both members who initiated the complaint require two persons for care. The Director of Nursing met with both members and explained that certain tasks require two people for safety protocol; thus, the need to return for member care with a two-person team.

10. **Concern:** On 12/13/19, a safety officer jumped out of a corner, startling a female staffer. A member expressed that he believed the safety officer's actions were inappropriate.

    Facility Response: Video was reviewed by staff and the incident was validated. The safety officer was educated on professionalism and customer service.

11. **Concern**: On 12/15/19, a member from 2 North expressed that activity staff are pulled from this unit more than other units within the Home.

    Facility Response: The member's concern was validated by management from the Life Enrichment Team. The manager will attend a 2 North Unit Meeting in January to address this issue. This incident occurred in December, which is a prime vacation month and several staff were on leave.

(c) Timeliness of distribution of pharmaceutical drugs.

FY 20 Q1:

DJJHV - Pharmaceutical drugs are delivered to medication rooms and medication carts at the Home every two weeks for distribution for the following two-week period.

GRHV – Pharmaceutical drugs are delivered the nursing units and medication carts at the Home every two weeks for distribution for the following two-week period.

(d) Security provided for pharmaceutical drugs in the facility, including the title of the individuals providing the security.

FY 20 Q1:

DJJHV - Pharmaceutical drugs are locked in the pharmacy, to which only the licensed pharmacists listed below have access. The pharmacy is equipped with an alarm. Narcotics are double locked within the pharmacy. On the unit(s), the medication rooms are locked, as are medication carts, and narcotics are double locked. The medication nurse on duty on any given shift is the only employee with the key to medications on the unit(s).

The following individuals provide the security and oversight of pharmaceutical drugs:

Brad Harvala, Pharmacy Director
Lori Krueger, Pharmacist
Barb Salmela, Pharmacist

GRHV- Pharmaceutical drugs are locked in the pharmacy, to which only the licensed pharmacists listed below have access. The pharmacy is equipped with an alarm. Narcotics are double locked within the pharmacy. On the units, the medication rooms are locked, as are medication carts, and narcotics are double locked. The medication nurse on duty on any given shift is the only employee with the key to medications on the units(s).

A PYXIS Medication Station located in the pharmacy entry way is available after hours. The front entry is only accessible via key card access when the pharmacy is closed. The PYXIS station is accessed via fingerprint or individual sign on with password; there is also a security camera located in the entry way.

The unit medication rooms are locked. Medication carts are locked with key access only; narcotics are double locked.

Returned medications to the pharmacy are handled via nursing and documented on a form. Returned medications are restocked or destroyed as appropriate. Returned medications are logged into the QS1 pharmacy system.

The following individuals provide the security and oversight of pharmaceutical drugs:

Christin Othmer, RPh
Fred Ammerman, RPh
Mary Butlevics, Pharm D

(e) How patient money is accounted for, including the name and title of the individual who supervises patient spending accounts.

FY 20 Q1:

DJJHV - Patient monies *held by the facility* are accounted for using generally accepted accounting principles, with interest applied to the balances quarterly.

The following individual supervises patient spending accounts:

Sean Depuydt, Business Manager

GRHV - Patient monies *held by the facility* are accounted for using generally accepted accounting principles, with interest applied to the balances quarterly.

The following individual supervises patient spending accounts:

Erica Bobrowski, Business Manager

(f) Number of facility resident deaths that occurred since the most recent report.

FY 20 Q1:

DJJHV - (20) facility deaths
GRHV – (21) facility deaths

(2) The department of military and veterans' affairs shall place the reports required under subsection (1) on its public website in a prominent and conspicuous manner.

This report has been published at www.michiganveterans.com