

STATE OF MICHIGAN MICHIGAN VETERAN HOMES LANSING

ANNE ZERBE EXECUTIVE DIRECTOR

January 10, 2023

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

Dear Governor,

SUBJECT: PA 351 of 2020 - FY '23 First Quarter Reporting

Attached please find the quarterly report from the Michigan Veteran Homes at Chesterfield Township, the Michigan Veteran Homes D.J. Jacobetti, and the Michigan Veteran Homes at Grand Rapids, pursuant to Public Act 351 of 2020, MCL 36.112a.

If you have any questions regarding this report, please contact Beth Simonton-Kramer at 616.498.5357.

Sincerely,

Anne Zerbe

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 Tommy Brann, House Appropriations Subcommittee on Military and Veterans Affairs Chair MG Paul Rogers, DMVA Director

GRETCHEN WHITMER GOVERNOR

Pursuant to Public Act 560 of 2016 (as amended by PA 351 of 2020), MCL 36.112a)

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 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 23 Q1:

Michigan Veteran Homes at Chesterfield Township (MVHCT) – 13.13 PPD Michigan Veteran Homes D.J. Jacobetti (MVHDJJ) – 4.70 PPD Michigan Veteran Homes at Grand Rapids (MVHGR) – 6.70 PPD

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

FY 23 Q1:

MVHCT - (0) Complaint forms submitted

MVHDJJ - (7) Complaint forms submitted – all complaints resolved within policy required time allotment.

1. Concern: On 7/19/2022, a member stated that his sweatshirt was missing.

Facility Response: The member's room was searched, and the laundry staff was notified; the sweatshirt was not found. A new sweatshirt was ordered for the member to replace the missing one.

2. Concern: On 7/29/2022, a member stated that he was missing six new shirts.

Facility Response: The housekeeping staff, laundry staff, and the supervisor were notified. The member's room was searched, but the shirts were not found; new shirts were ordered through Haberdashery.

3. **Concern:** On 8/3/2022, a member stated that his dentures were missing.

Facility Response: The supervisor and housekeeping staff were notified. The member's dentures were found and returned to the member.

4. Concern: On 8/3/2022, a member stated that he was missing a shirt.

Facility Response: The supervisor, housekeeping staff, and laundry staff were notified of the missing shirt. The member's room was searched but the shirt was not found. The member's shirt was returned with the laundry and labeled accordingly.

5. **Concern:** On 8/10/2022, a member stated that he was missing his driver's license.

Facility Response: The housekeeping staff, director of nursing, and supervisor were notified of the missing driver's license. The member's room was searched, the laundry was searched, and the member's driver's license was found and returned to the member.

6. Concern: On 8/15/2022, a member stated that he was missing his glasses.

Facility Response: The member's room and dayroom were searched, but the member's glasses were not found. Replacement glasses were ordered for the member.

7. Concern: On 9/9/2022, a member stated that he was missing six pairs of pants.

Facility Response: The director of nursing, supervisor, and housekeeping staff were notified of the missing items. Three pairs of the member's pants were found in the laundry and returned to member; three pairs of pants were replaced for the member.

MVHGR - (24) Complaint forms submitted – all complaints resolved within policy required time allotment.

1. Concern: A member reported that his I-Pad was missing.

Facility Response: Staff called the member's spouse and she verified that she took the member's I-Pad home with her. The member was satisfied with the resolution.

2. **Concern:** A member reported that his red cell phone was missing. He suggested that he may have left it at the Gun Lake Casino.

Facility Response: Staff called the casino and discovered that the member's cell phone was there. A social work manager went to the casino the next day, retrieved the cell phone, and brought it to the member.

Public Act 560 of 2016 (as amended by PA 351 of 2020), MCL 36.112a: State Veteran Home Reporting

3. **Concern:** A member reported concerns about medications and treatments being administered in the dining area which offends other members and is potentially violating HIPPA.

Facility Response: The LPN administering the medications and treatments was educated. In addition, education and an email were sent to all RNs and LPNs instructing them to refrain from this practice in order to preserve member dignity, unless a member specifically desires a med pass during meals times.

4. **Concern:** A member reported that his wallet was missing which contained \$150.00.

Facility Response: The laundry staff was instructed to look for the member's missing wallet and cash. The member's room and other areas in the neighborhood were extensively searched for the missing item. One month later, the member's wallet and cash were found in the member's closet.

5. **Concern:** A member reported that he was seated in the chapel awaiting the start of the weekly prayer meeting. A nurse asked him if she could take him out of the chapel and perform an assessment since she had to leave work early. By the time the assessment was completed, the prayer meeting had already started; the member was very upset.

Facility Response: A grievance officer completed an investigation to determine the identity of the nurse. The nurse was provided education regarding member preferences, and how they take precedence over an employee's agenda. Staff informed the member and the member's son of the results of the investigation and education provided.

6. **Concern:** A member reported that his glasses had been missing for a few months.

Facility Response: The member was then scheduled for an optician clinic to get his glasses replaced with no out-of-pocket cost.

7. **Concern:** A member reported concerns that all the correct food items were not being served on his meal trays consistently.

Facility Response: An investigation was completed by the nutrition manager who determined the employee, who was serving food, was new to that neighborhood. The neighborhood kitchen and employee were re-educated regarding food service. A care plan, including Kardex, was also updated with a task to ensure the necessary food items will be on the member's tray prior to delivery at mealtimes.

8. **Concern:** A member was very upset that someone in the business office had opened his mail from a bank; the mail contained his PIN number for his new debit card. The member was angry and upset, fearing that his debit card would have fraudulent charges on it as a result.

Facility Response: An investigation revealed that staff had accidently opened the envelope and attached a note apologizing for the incident. The grievance officer worked with the member and his bank to verify that there were no fraudulent charges on his account.

9. Concern: A member reported that his cell phone was missing.

Facility Response: The member's room was searched, and the phone was not found. A new phone was purchased, and the invoice was brought to the grievance officer for processing.

10. **Concern:** A member reported that his Christmas bead ornaments, bagged walnuts, scotch tape, and coins were missing.

Facility Response: The member's room was searched by a social worker and all items were found in the member's room.

11. **Concern:** A member expressed concern about staff not gowning up and closing the room door when entering to provide C-pap care; the member wants this concern addressed asap.

Facility Response: An investigation, including video surveillance, was completed by the infection control nurse. Staff education was provided so that all staff are aware of protocols; the member is satisfied with the resolution to this concern.

12. **Concern:** A member was unsatisfied with the period of time he had to wait to be toileted. The mechanical lift protocol requires two employees and the member had to wait for the second employee to arrive.

Facility Response: The member was provided with a copy of the mechanical lift manual and policy; the member was satisfied with this resolution to his concern.

13. **Concern:** A member complained about feeling as though staff were standing around and talking when members were waiting to be served at mealtimes.

Facility Response: A grievance officer followed up with CSU staffing supervisors and kitchen staff. It was determined that trays are only brought out when members are in the dining room and seated. Staff are waiting for trays to be delivered as soon as possible. The member was satisfied with the resolution of his concern.

14. **Concern:** A member reported his \$130.00 that he was keeping in secret places in his room was missing.

Facility Response: The member's currency was found in member's room (a total of \$160.00 was actually found). The member was encouraged to keep his valuables in his trust account or in his lockable drawer.

15. **Concern:** A member reported that he was missing an eagle ring and he hadn't seen it for over two months.

Facility Response: The member's room was searched, and two eagle rings were found in two different drawers. The member's admittance inventory was reviewed; he had 15 rings upon admittance. The search yielded 17 rings in his room; three of the rings were eagle rings. The member was satisfied with the resolution of his concern.

16. **Concern:** A member expressed concern about caregivers having offensive body odor and not treating him with dignity and respect.

Facility Response: The member was interviewed, and education was provided to care staff. The member reported the issues have resolved; staff are treating him respectfully and have good personal hygiene.

17. **Concern:** A member reported that his large office clip was missing; it had several \$5.00 bills attached to it. The member also stated that sometimes his neighbor mistakenly comes into his room.

Facility Response: The member's room was searched, and the laundry manager was notified of the missing items. The member's clip and money were never found. Identification signs for the members' rooms were created to decrease confusion.

18. **Concern:** A member stated that a third shift employee told him that he had to get his own Pullups from the bathroom shelf.

Facility Response: The member's concern was reviewed with the staffing agency supervisors to provide education to care staff. The issue was later reviewed with the member and the member is satisfied with the resolution.

19. Concern: A member reported that his wallet containing approximately \$80.00 was missing.

Facility Response: The member's wallet was returned from the laundry and contained several rolled-up bills totaling \$21.00. The member stated that the wallet and currency looked the same; thus, he was satisfied with the return of his wallet and considered the issue resolved.

20. **Concern:** A member reported that his request to have his hot chocolate warmed up in the microwave was denied by the caregiver, even after several repeated requests

Facility Response: An investigation was completed, including the review of videotape. The member was interviewed next day, and he denied that the caregiver said, "get out of my face". The investigation determined that caregiver in question was sitting down on couch and looking at her phone during this exchange. This caregiver was identified and is no longer working at the home. The member is satisfied with the resolution of the concern. 21. **Concern:** A member reported that he was missing \$125.00, and the last time he saw it was before he went to the hospital.

Facility Response: The member's room was searched twice by different staff with no success. After a social worker searched the member's room a third time, the member stated that the money must have been stolen. The member did not want police called to investigate. There was a suspicion of one particular caregiver, and with the member's approval at that time, a police report was filed. The caregiver was subsequently terminated. The member was asked if he wanted to be reimbursed by the facility and he said no, stating, "I don't need that money- I wasn't really even upset about it." The issue was resolved to the member's satisfaction.

22. **Concern:** A member reported missing \$11.00, and the last time he saw it was the previous week. The next day, the member then reported the money as stolen.

Facility Response: A full investigation was conducted, and the member's room was searched; the money was not located. The member's guardian was notified and asked if he wanted to file a police report or change the member's access to money. The guardian stated that the member routinely misplaces money and that he usually has small amounts in his possession. The member's care plan was updated to reflect the member misplacing money and guardian preferences.

23. **Concern:** A member reported missing \$117.00; the money was also reported stolen the next day.

Facility Response: The member's room was searched several times with a full investigation followed with staff interviews, guardian notifications, and care plan reviews. The member's guardian was satisfied with the facility investigation and response. The guardian does not want access to money to be restricted for the member. The member's care plan was updated to reflect these preferences and the fact that member will often forget to lock up his valuables.

24. **Concern:** A member reported that staff was being disrespectful. An employee was seated on a table with her feet up on a chair; this is where the member wanted to sit. When the employee was asked to move by another member, the employee rolled her eyes and did not comply with the request.

Facility Response: The member was interviewed by the administrator and director of nursing. The member does not feel abused but is not happy with the level of disrespect of the furniture and his home. Care staff were educated on showing respect for members and their home. The member was satisfied with the facility resolution to his concern.

(c) Timeliness of distribution of pharmaceutical drugs.

FY 23 Q1:

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

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

MVHGR – 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 23 Q1:

MVHCT - Pharmaceutical drugs are locked in the C2 safe within the pharmacy, to which only the licensed pharmacist listed below has sole access. The pharmacy requires a two-means of authentication in efforts to enter the pharmacy. 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 household.

A PYXIS Medication Station, located within the wellness center storage room for after-hours and weekend usage, only. The Wellness Center after-hours required key-card access, which is controlled, and a pre-determined group of Nurse Managers have specific key-card access to enter said storage room where the PYXIS is located.

The PYXIS station is accessed via individual sign on with password. There is also a security camera located in the Wellness Center in additional to the storage room.

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 individual provide the security and oversight of pharmaceutical drugs:

Kristie Schemansky, PharmD.

MVHDJJ - 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

MVHGR- 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 and 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: Louis Ciaramello, RPh

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

FY 23 Q1:

MVHCT - 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:

Renonda Mullen, Business Office Manager

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MVHDJJ - 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

MVHGR - 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:

Ashley Rawlings, Business Manager

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

FY 23 Q1:

MVHCT – 11 facility deaths **MVHDJJ** – 14 facility deaths **MVHGR** – 5 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.michigan.gov/mvh