



STATE OF MICHIGAN
MICHIGAN VETERAN HOMES
LANSING

GRETCHEN WHITMER
GOVERNOR

ANNE ZERBE
EXECUTIVE DIRECTOR

April 5, 2023

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

Dear Governor,

SUBJECT: PA 351 of 2020 – FY '23 Second 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,

A handwritten signature in cursive script that reads "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

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 Q2:

Michigan Veteran Homes at Chesterfield Township (MVHCT) – 10.57 PPD

Michigan Veteran Homes D.J. Jacobetti (MVHDJJ) – 4.77 PPD

Michigan Veteran Homes at Grand Rapids (MVHGR) – 6.60 PPD

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

FY 23 Q2:

MVHCT - (0) Complaint forms submitted – all complaints resolved within policy required time allotment.

MVHDJJ - (0) Complaint forms submitted.

MVHGR - (30) Complaint forms submitted – all complaints resolved within policy required time allotment.

1. **Concern:** A member's watch was mistakenly put in the washer and damaged.

Facility Response: The member's watch was replaced with one from the donation program; the member was satisfied with the resolution.

2. **Concern:** A member reported his coin purse containing \$52.00 was missing.

Facility Response: The member's coin purse was returned from the laundry later that day.

3. **Concern:** A member reported his gold watch was missing.

Facility Response: The member's watch was returned from the laundry later that day.

4. **Concern:** A member reported his milk had been delivered warm at two breakfast meals and one lunch meal.

Facility Response: The Nutrition Manager completed an investigation to include temperature logs and provided education to nutrition and caregiver staff. The member's milk was subsequently delivered cold, and the member was satisfied with the resolution.

5. **Concern:** A member's hearing aid was reported as missing.

Facility Response: The member's hearing aid was later returned from the laundry that same morning.

6. **Concern:** A member's new Marvin the Martian tee-shirt was reported as missing.

Facility Response: The member's shirt was returned from laundry on January 24, 2023.

7. **Concern:** A member reported \$70.00 in cash and two gift cards, worth \$30.00 each, were missing. The member had hidden the items in his room.

Facility Response: The member's room was searched, and the cash and gift cards were found in member's room behind a picture frame. The member's care plan was updated with the specifics of his hiding places.

8. **Concern:** A member reported his upper denture was missing.

Facility Response: The member's dentures were not missing; rather, they had been sent out for service.

9. **Concern:** A member reported that an LPN entered his room without knocking.

Facility Response: The LPN in question was interviewed and educated, emphasizing to knock loudly and receive permission prior to entering a room.

10. **Concern:** A member reported pushing his call light two times; however, no one came to answer it.

Facility Response: The ADON watched the video which confirmed CNA staff answered the member's call lights two times. The LPN on shift also confirmed the CNAs were in the member's room multiple times. This information was reviewed with the member and guardian; they were satisfied with the response.

11. **Concern:** A member expressed concern that his medication was discontinued without consulting the neurologist and without informing his spouse of the change.

Facility Response: An investigation determined the neurologist's recommendation was clarified with the physician; however, the member's spouse had not been notified. A new order list was reviewed in daily IDT to ensure the changes have been communicated to the member's family; the member was satisfied with the resolution.

12. **Concern:** A member expressed concern about the grade of meat the facility buys and meals served cold (less than 100 degrees). The member also noted that the gravy has a strange consistency, and his eggs were not cooked correctly.

Facility Response: The Food Service Director addressed each concern with the member individually and educated the kitchen staff about the member's preferences. The member realizes that the staff are trying to make things are better. The member was satisfied that his concerns had been addressed.

13. **Concern:** A member reported that staff entered his room without wearing proper PPE on February 1, 2023.

Facility Response: A review of video surveillance verified the member's report. This information was shared with the supervisor and staff education/discipline was provided.

14. **Concern:** A member reported his four keys on his lanyard were missing.

Facility Response: The member's room was searched without success. Laundry staff were notified of the missing keys. On February 7, 2023, the member's keys were found in a plastic bag in the member's room.

15. **Concern:** A member reported he was missing a box of Fixodent powder and a bottle of mouthwash from a shopping trip to Meijer.

Facility Response: The member's room was searched extensively and both items were found in the back of his bathroom drawers.

16. **Concern:** A member was upset when nursing staff entered his room and asked several questions; this interrupted his visit with family.

Facility Response: It was determined that CENA staff and a state surveyor were the staff who entered the member's room. The member was reassured that he always has the right to refuse entry to anyone, especially during family visits. The member's care plan was also updated to reflect the member's preference.

17. **Concern:** A member stated a contaminated stethoscope and blood pressure cuff were left in his room. The member asked staff to remove the items; staff told him they didn't have time to get them. The member also witnessed a doctor speaking with a member in the hallway; both individuals were unmasked.

Facility Response: The ADON explained that all items are left in the member's room while he was in isolation. The staff member was educated about wearing a mask fully on the face.

18. **Concern:** A member reported his dark brown wallet was missing which contained his driver's license and an undetermined amount of cash.

Facility Response: The Laundry Supervisor was notified of the member's missing wallet. As of February 17, 2023, the member's wallet had not been found or returned from the laundry. The member stated that the wallet is lost, and not stolen.

19. **Concern:** A member expressed several concerns about the food; he was previously a chef. He stated that cheap cuts of meat, the temperature of foods when served, and his morning eggs are not cooked correctly.

Facility Response: The Nutrition Manager and Head Chef met with the member to discuss his concerns. Staff are utilizing the member's suggestion for a better way to cook hard boiled eggs and are looking into better meat purchase options through the current supplier.

20. **Concern:** An LPN discovered that a member's right hearing aid was missing from the night shift.

Facility Response: The member's hearing aid was found.

21. **Concern:** A member reported his black wallet, and an undetermined amount of cash (\$20-30.00), was missing.

Facility Response: The Laundry Supervisor was notified of the member's missing wallet. The member's wallet had not been found nor returned from the laundry.

22. **Concern:** Medical staff determined that a member's hearing aid was missing.

Facility Response: The member's hearing aid was returned from the laundry.

23. **Concern:** During Member Council, many members on Pere Marquette and Lake Michigan reported care staff are not in nor near the dining room to assist with tray distribution; thus, making members wait for their meal trays on all shifts.

Facility Response: The Maxim and CSU supervising staff monitored the dining rooms during mealtimes, provided education to care staff, and completed a mandated training session. The members reported significant improvements have occurred with tray distribution.

24. **Concern:** A member reported he is missing his cell phone.

Facility Response: The member's phone was returned to the member after it came back from laundry.

25. **Concern:** A member reported his takeout food was either thrown away or eaten by someone else.

Facility Response: An investigation was completed with dietary/kitchen staff; video surveillance was also observed. No staff was observed walking out of the kitchen with a takeout box; caregivers reported the member had eaten the food.

26. **Concern:** A member reported two orange puffer vests were missing.

Facility Response: One of the member's puffer vest was returned to the member from laundry. The member's laundry slip indicated only one puffer vest had been sent to laundry.

27. **Concern:** A member's daughter alleged that upon returning from an all-night sleep test at the hospital, the third shift caregivers refused to give her mother a shower, stating "that is not my job".

Facility Response: Staff interviews were completed with the third and first shift care staff. Staff deny saying those words and worked with the CSU supervisor to make sure a shower was offered to the member. The offer of a shower was offered three times; the member declined as she was tired and wanted to go to bed. The member also stated she did not want to go on the trip because she was tired and wanted to sleep. The findings of the staff interviews were reviewed with the member's daughter.

28. **Concern:** A member reported that second shift staff do not like him.

Facility Response: The investigation is pending.

29. **Concern:** A member reported he asked for a pain pill but did not get it for 2 hours.

Facility Response: The investigation is pending.

30. **Concern:** A member reported missing clothing, including clothing protectors, a green shirt, an orange shirt, and a white shirt.

Facility Response: The investigation is pending.

(c) Timeliness of distribution of pharmaceutical drugs.

FY 23 Q2:

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 Q2:

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 Q2:

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

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 Q2:

MVHCT – 7 facility deaths

MVHDJJ – 7 facility deaths

MVHGR – 6 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