GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 2, 2021

Dustin Burritt
Grand Vista Living, LLC
99 Vista Drive
Coldwater, MI 49036

RE: License #: AL130389471
Investigation #: 2021A0584019
Grand Vista of Marshall 2

Dear Mr. Burritt:

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 responsible party 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. If I am not available and you need to speak to someone immediately, please contact the local office at (517) 284-9727.

Sincerely,

Candace L. Pilarski

Candace Pilarski, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 284-8967

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL130389471
Investigation #:	2021A0584019
Complaint Receipt Date:	06/16/2021
Investigation Initiation Date:	06/16/2021
Report Due Date:	08/15/2021
Licensee Name:	Grand Vista Living, LLC
Licensee Address:	99 Vista Drive Coldwater, MI 49036
Licensee Telephone #:	(517) 227-4055
Administrator:	Dustin Burritt
Licensee Designee:	Dustin Burritt
Name of Facility:	Grand Vista of Marshall 2
Facility Address:	206 Winston Court Marshall, MI 49068
Facility Telephone #:	(269) 248-6226
Original Issuance Date:	11/26/2018
License Status:	REGULAR
Effective Date:	05/26/2021
Expiration Date:	05/25/2023
Capacity:	20
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
About a week and a half ago, Resident A fell in her room and was found on the floor. She was later crying and said her head hurt. Family was not notified of Resident A's fall and injuries.	No
Lack of proper medical care.	No
Failure to provide food unless asked for when Resident A is unable to ask for food.	No
Additional Findings	Yes

III. METHODOLOGY

06/16/2021	Special Investigation Intake 2021A0584019
06/16/2021	Special Investigation Initiated - Telephone With Dawn Campbell, consultant
06/29/2021	Contact - Face to Face Interview with Erica Burritt, Home manager
06/29/2021	Contact - Face to Face Interview with Dustin Burritt, Licensee Designee
06/29/2021	Contact - Face to Face With Resident A
06/29/2021	Contact - Face to Face Interview with Sylvia Culliver, Direct Care Worker
06/29/2021	Contact - Face to Face With Taylor Brankovich, Direct Care Worker
06/29/2021	Contact - Face to Face With Laiken Skidmore, Direct Care Worker
07/06/2021	Contact - Telephone call made Interview with Guardian A-1
07262021	Exit Conference Via email sent to Dustin Burritt, licensee designee.

ALLEGATION:

About a week and a half ago, Resident A fell in her room and was found on the floor. She was later crying and said her head hurt. Family was not notified of Resident A's fall and injuries.

INVESTIGATION:

On June 29, 2021, I conducted an unannounced inspection onsite at the home. I was met by direct care worker Laiken Skidmore at the front desk. I met with Erica Burritt and Dustin Burritt in the facility office and asked to see a staff schedule and reports of any accidents that may have occurred with the residents in the beginning weeks of June 2021. Ms. Burritt keeps records of incidents within the facility on the computer. I asked Ms. Burritt if she has any information regarding Resident A having a fall between the end of May and any time until this day. Ms. Burritt searched the computer database and stated there was no record or staff note of Resident A having a fall in late May or early June. Ms. Burritt found a staff note that Resident A did have a fall noted on June 15, 2021, where she slipped off the couch in her bedroom. Ms. Burritt stated this was the only note of a fall incident that she has or recalls. Ms. Burritt said Resident A was assisted and observed at the June 15, 2021, date where vitals were taken. There was no hospitalization at that time. Mr. Burritt provided the staff directory and schedule of daytime workers back to the beginning of June. Three of the direct care workers on the schedule were present for face-to-face interviews.

On June 29, 2021, I reviewed Resident A's facility file and did not find any incident reports to view.

On June 29. 2021, I viewed Resident A who was asleep in a recliner sitting in the living room area. Staff tried to awaken Resident A, but she was sound asleep and did not completely awake to be asked questions. I did not see any evidence of bruises on Resident A's exposed skin or face on this date.

APPLICABLE RULE	
R 400.14311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following: **(a) The death of a resident.** **(b) Any accident or illness that requires hospitalization.** **(c) Incidents that involve any of the following:**

	(i) Displays of serious hostility. **(ii) Hospitalization.** **(iii) Attempts at self-inflicted harm or harm to others.** **(iv) Instances of destruction to property.** **(d) Incidents that involve the arrest or conviction of a resident as required pursuant to the provisions of section 1403 of Act No. 322 of the Public Acts of 1988.**
ANALYSIS:	The facility is required to notify the department with a written incident report if any of the above circumstances apply. Allegedly, Resident A had a fall sometime in early June. There was no incident report found in Resident A's file or in the department facility file for Resident A. No hospitalization was obtained for Resident A during that time period and there were no other incident notes recorded by staff. Licensing rules for incident report notification do not require a family notification outside of the circumstances listed above. There is not enough evidence to determine a rule violation occurred.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Lack of proper medical care.

INVESTIGATION:

On June 29, 2021, I conducted a face-to-face interview with Sylvia Culliver. Ms. Culliver is a direct care staff who regularly works on the morning shift. Ms. Culliver was scheduled in the early weeks of June and verified she worked those days. Ms. Culliver was asked if she is familiar with Resident A. Ms. Culliver stated she is very familiar with Resident A. Ms. Culliver was asked to talk about any recent falls that Resident A had. Ms. Culliver stated she has not seen or heard of any recent falls by Resident A and stated she has not witnessed or heard of any falls from today back to the Memorial Day holiday. Ms. Culliver was asked if she recalls any visible injuries to Resident A in the past four weeks. Ms. Culliver stated she does not recall any obvious injuries that were visible on Resident A. Ms. Culliver was asked to verify the process in which to report any injury or fall. Ms. Culliver stated the process is to assess the resident and provide any needed first aid, then to contact Erica Burritt with the information to get direction on how to proceed from there, and finally monitor vital signs of the resident to make sure they are doing ok. Ms. Culliver understood that, if necessary, medical care would be secured for a resident if the situation required.

On 6/29/2021, I conducted a face-to-face interview with direct care staff Taylor Brankovich. Ms. Brankovich normally works day shift hours at the home. Ms.

Brankovich stated that she was not working the very first week of June that she recalled. Ms. Brankovich was asked if she knew Resident A and she responded she did know her. Ms. Brankovich was asked if she recalled any time in the last four weeks that Resident A fell or showed any signs of visible injuries such as bruising. Ms. Brankovich stated she has not witnessed any falls by Resident A but did see a "bump" on Resident A's head and bruising around both eyes when she returned back to work early June. Ms. Brankovich stated the bruises were noticeable to her and the bump on her forehead was noticeable. Ms. Brankovich said that Resident A had become very unsteady on her feet within the last month where she required more assistance. Ms. Brankovich said that Resident A used to be a lot more mobile a couple of months ago. Ms. Brankovich was asked what the facility procedure is when a resident has an accident such as a fall. Ms. Brankovich said she would immediately assist and assess the resident's vital signs to determine what may need to be done and then contact Erica or Dustin Burritt to alert them and to get further instructions or interventions needed. Ms. Brankovich understood that medical care would be obtained, if needed, for a resident.

On June 29. 2021, I conducted a face-to-face interview with Direct Care staff, Laiken Skidmore. Ms. Skidmore regularly works daytime hours at the home. Ms. Skidmore was on the schedule for the first couple of weeks in June and stated she did work the days scheduled. Ms. Skidmore was asked if she was familiar with Resident A. Ms. Skidmore stated she was very familiar with Resident A. Ms. Skidmore was asked if she had seen Resident A fall at the facility or if she had any observable bruising or marks on her body anytime between today and back to Memorial weekend. Ms. Skidmore did not recall any time there was bruising or marks on Resident A and also did not recall seeing Resident A fall during that time. Ms. Skidmore was asked to describe the home policy regarding a resident falling or appearing to need assistance. Ms. Skidmore stated she would assist the resident and observe by taking vital signs. Ms. Skidmore stated she would contact Dustin Burritt or Erica Burritt and inform them of any falls, accidents, or incidents where they would further advise on intervention at that point. Ms. Skidmore understood the need for obtaining medical care for a resident when needed.

On 7/6/2021, I conducted a phone interview with Guardian A1. Guardian A1 said that Resident A uses their own family doctor whose nurse practitioner is a relative of Resident A. Guardian A1 visits with Resident A as often as she is able which is usually once per week. Guardian A1 stated that she has not had any concerns about Resident A's medical care when required and feels the facility would act in Resident A's best interest if immediate medical care was needed. Guardian A1 stated about three weeks ago, the facility manager Erica Burritt contacted the doctor and informed of some changes in Resident A's mobility. Guardian A1 said the doctor did make some medication changes at that time.

APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	After interviewing three staff members, they understand what is required in the event of an accident or sudden change in a resident's wellbeing. There was no evidence found or discovered that the facility has not obtained needed care when necessary. Resident A's guardian has had no complaints of care or concerns the facility has not acted immediately in Resident A's needs.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Failure to provide food unless asked for when Resident A is unable to ask for food.

INVESTIGATION:

On 6/29/2021, I reviewed Resident A's weight record. Resident A is weighed every month and she has lost about 20 pounds in the last five months. Resident A's weight listed at the time of visit was 152.

On 6/29/21, I conducted a face-to-face Sylvia Culliver, direct care worker. Ms. Culliver stated she is not aware of any resident at the home being purposely withheld food.

On 6/29/2021, I conducted a face-to-face Taylor Brankovich, direct care worker. Ms. Brankovich stated that all residents are given food at designated mealtimes. Ms. Brankovich has not heard or witnessed any resident being purposely denied food. Ms. Brankovich stated Resident A requires more assistance as her dementia worsens, but she is offered food and assisted with eating.

On 6/29/2021, I conducted a face-to-face Laiken Skidmore, direct care worker. Laiken stated that Resident A has had issues with swallowing food, so they have been serving her soft foods. Ms. Skidmore stated that Resident A has meals in the dining area and staff sits with her to assist with her mealtimes. Ms. Skidmore stated that Resident A is not able to communicate or ask for food, but the staff make sure they help Resident A eat at mealtimes. Ms. Skidmore stated she has not witnessed food withholding from Resident A.

On 7/6/2021, I conducted a phone interview with Guardian A1. Guardian A1 stated when she visits Resident A, it is usually near or at lunch time where she will sit and assist in feeding. Guardian A1 said Resident A does not make much sense when communicating and when she does, she is not oriented to person, place, time. Guardian A1 does not feel that Resident A would ask for food or the facility would withhold or not provide meals.

APPLICABLE RULE	
R 400.15308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(e) Withhold food, water, clothing, rest, or toilet use.**
ANALYSIS:	After reviewing Resident A's weight record where it is required by the department for the resident to be weighed at least one time a month, Resident A's weight appears to be within normal range for her stature and height. The staff interviewed stated they assist her eating at mealtimes and do not withhold food. Staff interviewed stated that all residents will be assisted if needed at every mealtime. Guardian A1 visits often and does not have any concerns about Resident A's weight and eating at the facility.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On June 29. 2021, I reviewed Resident A's *BCAL-3265 ASSESSMENT PLAN FOR AFC RESIDENTS* that was filed in her facility file. The facility was using a wheelchair to assist Resident A with mobility within the facility on a daily basis. Although the facility did have the physician assistant verify this assistive device can be utilized, the plan was not updated and signed by the designated representative.

On 7/6/21, I interviewed Guardian A1 via a phone call. Guardian A1 was aware the facility was using their wheelchair onsite to transport Resident A about the facility. Guardian A1 had not reviewed or signed a resident assessment form regarding the planned use of the wheelchair.

APPLICABLE RULE	
R 400.15306	**Use of assistive devices.**
	(2) An assistive device shall be specified in a resident's written assessment plan and agreed upon by the resident or the resident's designated representative and the licensee.
ANALYSIS:	There was not a resident assessment plan for Resident A where the use of a wheelchair as an assistive device was defined and signed by the Guardian A1. The assessment plan that was in Resident A's file showed that Resident A had unrestricted mobility and use of no assistive devices.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 6/29/21, I conducted a face-to-face interview with Taylor Brankovich, direct care worker. Ms. Brankovich stated when she was off work for a few days in early June, she returned to work and noticed Resident A had a bump on her head and two black eyes from bruising. Ms. Brankovich stated the bump and bruising was noticeable. Ms. Brankovich stated she heard from another employee (who no longer works at the facility) that Resident A had a fall but did not know the details of what happened or how the bump occurred. Ms. Brankovich stated that early in the month, Resident A had a habit of moving her furniture around and she was not one to sit still. Ms. Brankovich noticed that Resident A's nightstand was moved away from the bed to another part of the room and thought maybe she may have bumped her head on it when it was close to the bed. Ms. Brankovich did not find or observe a staff report on this incident to review.

On 7/6/21, I conducted a phone interview with Guardian A1. Guardian A1 did notice the black eyes and knot on Resident A's head when she visited in early June. Guardian A-1 did not have the exact date when she saw the bruises and bump. Guardian A-1 did not feel that Resident A appeared to require hospitalization as a result of the visible injuries she viewed. Guardian A-1 stated Resident A does stay up after sundown and is quite active during those times. Guardian A-1 stated that Resident A-1 has thin skin being elderly and may bruise easily as a result.

APPLICABLE RULE	
R 400.15311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(6) An accident record or incident report shall be prepared for each accident or incident that involves a resident, staff member, or visitor. "Incident" means a seizure or a highly

	unusual behavior episode, including a period of absence without prior notice. An accident record or incident report shall include all of the following information: **(a) The name of the person who was involved in the accident or incident.** **(b) The date, hour, place, and cause of the accident or incident.** **(c) The effect of the accident or incident on the person who was involved, and the care given.** **(d) The name of the individuals who were notified and the time of notification.** **(e) A statement regarding the extent of the injuries, the treatment ordered, and the disposition of the person who was involved.** **(f) The corrective measures that were taken to prevent the accident or incident from happening again.** **(7) A copy of the written report that is required pursuant to subrules (1) and (6) of this rule shall be maintained in the home for a period of not less than 2 years. A department form shall be used unless prior authorization for a substitute form has been granted, in writing, by the department.**
ANALYSIS:	As a result of information obtained by two interviews, an incident or accident occurred in early June that resulted in visible injuries on Resident A. There was no evidence obtained to determine if the accident required hospitalization. The rule states that if any incident or accident occurs, an incident report is to be completed. No incident report was found that described an accident where Resident A acquired a knot on her forehead and two black eyes. An incident report would be required to document an accident such as this. Since no report was done, none was found in Resident A's file.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receiving an acceptable corrective action plan, I recommend no change in the status of this license.

7/30/31

Candace Pilarski Date
Licensing Consultant

Approved By:

08/02/2021

Dawn N. Timm Date
Area Manager