GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 31, 2021

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

RE: License #: AL130389471

Investigation #: 2021A1029017
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 licensee designee 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 (231) 922-5309.

Sincerely,

Jennifer Browning, Licensing Consultant
Bureau of Community and Health Systems
Browningj1@michigan.gov
(989) 444-9614

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL130389471
Investigation #:	2021A1029017
Complaint Receipt Date:	07/12/2021
Investigation Initiation Date:	07/14/2021
Report Due Date:	09/10/2021
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?
There is inadequate staffing since the resident's call buttons do not work and staff do not check on the residents.	No
The resident's medications are managed poorly.	Yes
The food was not prepared and served appropriately.	No

III. METHODOLOGY

07/12/2021	Special Investigation Intake 2021A1029017
07/13/2021	Contact - Telephone call made to complainant and left a message
07/14/2021	Special Investigation Initiated - Face to Face with Resident A and B, and direct care staff members Laiken Skidmore, Sylvia Culliver, Sarah Clark at Grand Vista of Marshall 2
07/29/2021	Contact - Telephone call made to Resident A
07/29/2021	Contact - Telephone call made to Dr. Valle office - spoke with Tina Hackworth.
08/02/2021	Contact - Face to Face with Erica Burritt, Resident A, Relative A1
08/03/2021	Contact - Document Received - Email from Dustin Burritt with the letter from Resident A's physician
08/04/2021	Contact - Document Sent email to Dustin Burritt
08/11/2021	Exit Conference with Dustin Burritt

ALLEGATION:

There is inadequate staffing since the resident's call buttons do not work and staff do not check on the residents.

INVESTIGATION:

On July 12, 2021, an investigation was received via a rejected APS referral from Centralized Intake. The complaint alleged that the call lights were not working and residents were not being cared for in a timely manner.

On July 14, 2021, I interviewed Resident A at Grand Vista of Marshall 2. She was in her room. She stated that one time the call buttons in the facility did not work. She stated one of the direct care staff members took the call button home with them so the other staff did not have one to use. The direct care staff member that took the pager home could not return it because she lived too far away. Resident A stated she heard that Resident B pushed their call light for over two hours and no one noticed to assist her.

On July 14, 2021, I interviewed Resident B at Grand Vista of Marshall 2. She stated that she has a call button but she does not think that it works all the time. She said that on Sunday morning she was trying to reach someone to come help her transfer from her bed for over an hour but they did not come in until direct care staff member, Sylvia Culliver arrived for day shift. Resident B heard that one of the staff did not leave the pager at the facility and instead went home with it. Resident B stated that has not happened before and feels that the staff are pretty attentive to her needs. Resident B stated she receives good care at Grand Vista of Marshall 2 and likes living there.

On July 14, 2021, I interviewed direct care staff member, Sylvia Culliver. She stated that she did hear that a pager was taken home by a staff member. She stated that sometimes this happens since they carry them on their pocket and they are easy to miss however, they always have extra pagers in the building to use as a backup. She was not aware that Resident B went without care or was unable to call for assistance because her call light was not working during third shift.

On July 14, 2021, I interviewed direct care staff member, Laiken Skidmore at Grand Vista of Marshall 2. She stated she did leave the facility with the pager in her pocket. Ms. Skidmore was called by another direct care staff member on third shift to bring it back but she told them there were extras and she would bring it back during her next shift. She stated that she lives over an hour away. She did tell the direct care staff member that called her that she would bring it back if they could not find the backup pagers and to call her back. Ms. Skidmore stated she did not hear back from any of the direct care staff members that night so she assumed they found the backup pagers. She stated they have several other pagers they can use so if someone leaves with one, there would be no reason for the residents to not receive care. There are three other pagers that are usually kept at the nurses' station they can use.

On August 2, 2021, I interviewed nursing director, Erica Burritt at Grand Vista of Marshall 2. She stated they have been doing well with staffing. She stated each direct care staff member has a call light pager and the residents all have a pendant call light they wear. There are also switches for the call lights on the wall in the resident rooms. In the past, there has been times the pager went home with a direct care staff member. Ms. Burritt stated this does not interrupt services to the residents since they have several other pagers that the direct care staff members can use.

She stated they also have batteries in the drawer in case they are ever low on batteries so there is never a time that the call light system does not work. Ms. Burritt was not aware of a time that Resident B or any other resident had to wait for care. Ms. Burritt stated that she heard Resident A talking about this concern in the past but she was not aware that any residents went without care.

APPLICABLE RULE	
R 400.15206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	Direct care staff member, Laiken Skidmore took the pager for the call light system home with her after she ended her shift. All employees interviewed indicated there are several more the direct care staff members can use for a backup. Based on my investigation which included interviews with direct care staff members, nursing director, Erica Burritt and licensee designee, Dustin Burritt there is no evidence to support the allegation that residents are not being cared for as a result of the pager going home with one of the direct care staff members.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident medications are managed poorly.

INVESTIGATION:

On July 12, 2021, I received this complaint through a rejected APS referral from Centralized Intake. The complaint alleged that Resident A's medication was not given as prescribed.

On July 14, 2021, I conducted an onsite investigation at Grand Vista of Marshall 2 and interviewed Resident A. Resident A stated when she first arrived, she had the direct care staff members pass her medications. She stated that she takes Coumadin-6mg on Monday, Wednesday, and Friday and on the other days she takes 5mg Coumadin per day. Resident A stated this was confusing to the staff and there was one time she told the direct care staff member that the medication was not correct. Resident A stated she could not remember who the direct care staff member was she told this to or when this occurred but stated that since that time there has been no concerns with her medications.

On July 14, 2021, I interviewed with Resident B who confirmed the direct care staff member pass all her medications. She has not had any concerns but sometimes she believes they forget her Metformin in the evening. She is supposed to take two tablets in the morning and one in the evening. Resident B stated that she believes it was missed a couple weeks ago but did not know the date or who was working. Resident B stated she keeps her diabetes under control mostly with her diet so she was not concerned about missing one dosage of the Metformin.

On July 14, 2021, I interviewed direct care staff member Laiken Skidmore at Grand Vista of Marshall 2. She stated she was not trained to pass medications yet but she was able to pull up Resident B's medication to show it was Metformin Hydrochloride 850 mg. She was able to print off her medication administration record (MAR) for the Metformin Hydrochloride for the last sixty days and there was only one day that she did not receive her Metformin in the evening on Sunday, May 23, 2021 and there was a notation (Refused – out of building) in the MAR. All other days, she received the Metformin medication as prescribed.

On July 14, 2021, I interviewed direct care staff member Sarah Clark at Grand Vista of Marshall 2. With her assistance, I was able to review the medications in the MAR and the medication cart for Resident B. All medications in the medication cart matched the medication that was documented in Resident B's MAR. She did have one medication of Citalopram Hydrobromide that had label instructions to discard after December 2, 2020, however the medication was still in the medication cabinet as was the medication Potassium Chloride that had the same label instructions to discard after December 2, 2020. Both of those medications were still in the medication cart but were not discarded. They were sat aside in the drawer in the medication cart and not included in her regular rotation of medications. Ms. Clark took them out of the medication cart and stated she would give them to Ms. Burritt to discard the medications.

Ms. Clark could not find any medications for Resident A in the cart. According to the MAR, all Resident A's medications were on hold and she was not sure why there was not anything in the cart. She did not see any of the medication orders and that Mr. Burritt would need to be contacted because he would know why they were on hold since January 27, 2021.

On July 14, 2021, I interviewed Relative A1. She stated that she cannot recall when the medications were wrong for Resident A, however, since she has been taking them on her own, there has not been any concerns. Relative A1 could not remember when Resident A started taking the medication on her own. Relative A1 was asked if they received a letter or order from Resident A's medical professional documenting she is able to self-medicate and she stated they did this recently. Relative A1 did not have any concerns that Resident A was able to take her own medications and stated she has had no concerns with her doing this on her own.

Relative A1 was unsure if Resident A's medications were locked in Resident A's resident bedroom.

On August 2, 2021, I interviewed Resident A and Relative A1 at Grand Vista of Marshall 2. Relative A1 was there helping Resident A pack up her belongings because she was moving to another facility. Resident A was asked about her medications. She just finished taking them and was able to explain what medication she takes and when. She appeared to be able to independently administer her own medications. She had a medication organizer that she used for the medication as well as a smaller one she can organize the medications if she is leaving the facility for the day. Resident A stated she stores her medications in the drawer that does lock but the lock is now broken. She stated she has mentioned the broken lock to licensee designee Dustin Burritt as the lock has been broken for a while. Resident A seemed to be excited about moving to another facility. Relative A1 was also there and had no concerns regarding Resident A taking her own medications.

On August 11, 2021, during the exit conference with licensee designee Dustin Burritt, he stated he was not aware that Resident A needed a letter documenting that she could independently administer her own medications. He stated he recently had the inspection for his license renewal with adult foster care licensing consultant, Dawn Campbell on May 19, 2021 who informed him of this requirement. As a result of that inspection, he received a note from Resident A's doctor stating that she could give her medications independently. Mr. Burritt stated he was not aware of the broken drawer and if he was notified, he would have put a new lock on the drawer. During the renewal inspection, Mr. Burritt stated the facility was also cited for not having Resident A's medications locked as required. Both of these violations were reviewed in the licensing study report signed by Dawn Campbell on May 24, 2021.

On August 2, 2021, I interviewed the nursing director, Erica Burritt at Grand Vista of Marshall 2. She stated that they had a recent licensing renewal and that is when she was informed by Dawn Campbell that documentation from Resident A's health care professional was needed in order for Resident A to self-administer her own medications. Ms. Burritt stated that Resident A was getting the care required and at times Resident A will express concerns regarding her care which they try to address with her. I was able to review the resident record for Resident A. The medications listed on her health care assessment from May 2021 match the medications that Resident A told me she is prescribed.

Resident B supplies her own medications to the facility. She was not familiar with a time that she missed her Metformin. She was able to pull up the medications for Resident B for the last 60 days and there was no missing Metformin dosage for June or July 2021. The only change to Resident B's medication would be that if her heart rate or blood pressure are elevated then she does not receive her Lisinopril.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Resident A self-administers her own medication and was able to show during the onsite investigation that she was aware of each medication that she was prescribed and could explain when to take each medication. Relative A1 also confirmed that she had no concerns with Relative A taking her own medications. Both of these violations were reviewed in the licensing study report signed by Dawn Campbell on May 24, 2021 and licensee designee, Mr. Burritt obtained a letter from her health professional confirming that she could self-administer her medications.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being {333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.

ANALYSIS:	Resident A self-administers her medication and the medications were not locked as required. There is a drawer in the kitchenette area for the medications with a lock, however, the lock on the drawer was broken. The medications not being locked in Resident A's room were reviewed at the inspection and in the licensing study report signed by Dawn Campbell on May 24, 2021. During the onsite investigation August 2, 2021, the lock on the medication drawer in Resident A's room was still broken.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED. [SEE RENEWAL LSR DATED 5/24/2021. CAP APPROVAL DATED 6/14/2021].**

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(7) Prescription medication that is no longer required by a resident shall be properly disposed of after consultation with a physician or a pharmacist.
ANALYSIS:	There were also two medications for Resident B (Citalopram Hydrobromide and Potassium Chloride) with label instructions to discard after December 2, 2020, that remained in the medication cart on July 12, 2021. The two medications were not properly disposed of in December 2020 after they were no longer required.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The food was not prepared and served appropriately.

INVESTIGATION:

On July 12, 2021, an investigation was received via a rejected APS referral from Centralized Intake. The complaint alleged that the food in at Grand Vista of Marshall 2 was not prepared and served appropriately.

On July 14, 2021, I interviewed Resident A at Grand Vista of Marshall 2. She stated that she has had burnt food in the past and does not enjoy the food offered at Grand Vista of Marshall 2. She gave an example of a time she cut into her roast beef and then realized it was a burnt potato. She stated that the crust on the pot pie did not look good in the past. She states that the night shift prepares the food and then it is

reheated for the next day. Resident A would prefer better food so she plans on moving to a smaller facility because she believes the food will taste better.

On July 14, 2021, I interviewed Resident B at Grand Vista of Marshall 2. Resident B stated that sometimes the food is good and sometimes it is not. Resident B stated the facility should have a regular cook to prepare their meals instead of "just whoever is working that day." Resident B stated she has observed that some of the direct care staff members do not prepare the meals as good as others. Resident B stated most times there are three or four staff members working but, on the weekends, there are typically two. She denied having food that was burnt or not prepared well rather she has simply had food in the past that did not taste that good.

On July 14, 2021, I interviewed direct care staff member, Laiken Skidmore. She was working in the kitchen at the time of the inspection. She was able to show me the pantry and food in the refrigerators. She states that whoever is working that day is the one that prepares the food. She denied that she has been through a formal training regarding how to prepare the food, but they have a menu they follow. She feels comfortable preparing meals for the residents. There were thermometers in each refrigerator and freezer and all the food was kept at a safe temperature.

On July 14, 2021, I interviewed direct care staff member, Sylvia Culliver. She stated that she has worked during shifts she had to prepare meals. She stated the residents typically do not complain about what is served. Ms. Culliver stated that she completed a nutrition and food safety training when she started her employment and she feels comfortable preparing the meals for the residents.

On July 14, 2021, I interviewed Relative A1. She stated she has heard complaints from Resident A regarding the food being undercooked or overcooked. Some days are better than others depending on which staff is working. She stated licensee designee, Dustin Burritt told her he was going to get some recipes and train the staff to cook better meals. Relative A1 feels that most food is from Gordon's Food Service and that Mr. Burritt buys quality food but the staff members may not know how to make it correctly.

On August 2, 2021, I spoke with nursing director, Erica Burritt at Grand Vista of Marshall 2. Ms. Burritt stated that all direct care staff members complete a food and nutrition training when they begin employment which includes training in the kitchen for preparation and presentation of the meals. One of the direct care staff members on each shift is responsible for preparing the meals for that day. Typically, the third shift direct care staff member does most of the food preparation and makes the dessert the night before. They use SYSCO as their food supplier and they also have a nutritionist assigned through SYSCO. Ms. Burritt was able to produce the most recent menus for review as well as a full alternative menu in case a resident does not like what is served. The facility also has a cook to order breakfast so residents can choose what to eat for breakfast.

During the exit conference on August 11, 2021, licensee designee, Mr. Burritt stated they train their staff how to prepare the meals for the facility. He stated that each direct care staff member completes a training. The direct care staff members take a nutritional test after they complete the training. The residents have an alternate menu in case there are items they do not like. Mr. Burritt produced a sample of the nutritional test and there were a variety of questions related to food preparation and safety.

APPLICABLE RULE	
R 400.15313	**Resident nutrition.**
	(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.
ANALYSIS:	The onsite investigation was not done during meal times. However, the food at the facility appeared safe and free from spoilage and contamination, the food service equipment was in good repair, and the facility appeared equipped to prepare and serve adequate meals. The fridges had thermometers and were kept at a safe temperature. During the first visit to the home, there were two meals that were recently prepared that were leftovers. Both of them looked appetizing and did not appear to be under or over cooked. The residents receive three meals per day plus snacks. Ms. Burritt was able to produce the menus showing what the residents are receiving along with back up choices for each day if they do not want the meal on the menu. They also have a cook to order breakfast. It appears that the residents have adequate choices of nutritious foods.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an approved corrective action plan, I recommend no change in the license status.

Jennifer Browning 8/30/2021

Jennifer Browning
Licensing Consultant
Date

Approved By:

Dawn Timm 08/31/2021

Dawn N. Timm
Area Manager
Date