GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 15, 2022

James Maxson
Grand Vista Properties, LLC
13711 Lyopawa Island
Coldwater, MI 49036

RE: License #: AL120406800
Investigation #: 2022A0007009
Grand Vista Properties

Dear Mr. Maxson:

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. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (313) 456-0380.

Sincerely,

Mahtina Rubritius

Mahtina Rubritius, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd., Ste. #9-100
Detroit, MI 48202
(517) 262-8604

Enclosures

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

I. IDENTIFYING INFORMATION

License #:	AL120406800
Investigation #:	2022A0007009
Complaint Receipt Date:	12/16/2021
Investigation Initiation Date:	12/16/2021
Report Due Date:	02/14/2022
Licensee Name:	Grand Vista Properties, LLC
Licensee Address:	13711 Lyopawa Island Coldwater, MI 49036
Licensee Telephone #:	(517) 227-5225
Administrator:	James Maxson
Licensee Designee:	James Maxson
Name of Facility:	Grand Vista Properties
Facility Address:	99 Vista Drive Coldwater, MI 49036
Facility Telephone #:	(517) 227-5225
Original Issuance Date:	12/29/2020
License Status:	REGULAR
Effective Date:	06/29/2021
Expiration Date:	06/28/2023
Capacity:	20
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident A has been threatened with being kicked out. The owner back dated the written 30-day notice.	No
There were several times when Resident A was not given medication the doctor ordered, and the staff have lost Resident A's medication.	Yes
Allegations that staff were told not to talk to Resident A and to feed her last. Resident A is isolated.	No

III. METHODOLOGY

12/16/2021	Special Investigation Intake - 2022A0007009
12/16/2021	Special Investigation Initiated – Letter - APS Referral made by Intake worker.
12/16/2021	APS Referral made.
01/06/2022	Inspection Completed On-site - Unannounced - Face to face contact with Mr. Maxson, Licensee Designee.
01/18/2022	Contact - Document Received - Email from Family Member #1.
01/18/2022	Contact - Document Sent - Email to Family Member #1.
02/07/2022	Contact - Telephone call made to Family Member #1. Phone number no longer in service.
02/07/2022	Contact - Document Sent Email to Family Member #1. I requested that she give me a call.
02/08/2022	Contact - Telephone call received - Case discussion with Family Member #1.
02/08/2022	Inspection Completed On-site - Face to face contact with Mr. Maxson, Licensee Designee, Employee #1, Home Manager #1, Nurse #1, Resident A, along with other staff and residents.

02/08/2022	Contact - Document Received from Family Member #1.
02/11/2022	Contact - Telephone call made to Family Member #1, Follow up questions.
02/14/2022	Contact - Document Sent to Mr. Maxson. Copy of the information regarding mask requirements in AFC homes.
02/14/2022	Exit Conference – Conducted with Mr. Maxson, Licensee Designee.
02/14/2022	Contact - Telephone call message received from Family Member #2.
02/14/2022	Contact - Telephone call made to Family Member #1, Follow up questions.
02/14/2022	Contact - Telephone call made to Family Member #2.

ALLEGATIONS:

Resident A has been threatened with being kicked out. The owner back dated the written 30-day notice.

INVESTIGATION:

On January 6, 2022, I conducted an unannounced on-site inspection and made face to face contact with Mr. Maxson, Licensee Designee. He informed me that there were positive covid cases in the facility; therefore, I did not enter the facility. I briefly spoke with Mr. Maxson and informed him of the special investigation regarding Resident A. Mr. Maxson informed me that he “kicked her out for disturbing the peace.” Mr. Maxson went on to explain that Resident A and her children were causing problems. He recalled that Resident A had been in two other placements within the last year, and this was her third placement. Mr. Maxson informed me that Resident A has a history of turning things around and not reporting what really happened. He recalled that Home Manager #1 overheard Resident A on the phone, saying things that were not true. I informed Mr. Maxson that I would follow-up with him regarding this investigation at a later date.

On February 8, 2022, I interviewed Family Member #1 (FM #1) via telephone. FM #1 informed me that her mother, Resident A, is still in the home. She expressed concerns as when they have attempted to find other apartments, Mr. Maxson has

given bad references, making it more difficult to locate other housing. FM #1 stated that her mother, (Resident A), was given an eviction notice but it was not from the court. I explained to her that per licensing rules, the license must provide the resident and their responsible parties with a 30-day written discharge notice. FM #1 stated that on December 3, 2021, Mr. Maxson stood by her mother's door and stated, "You're out of here, you have 30-days." The written 30-day notice was dated December 3, 2021, and she (FM #1) received it in the mail about a week later. FM #1 informed me that her mother was being evicted because she took pictures of residents in the common areas of the home, and she had a bad attitude.

According to FM #1, on January 10, 2022, Mr. Maxson stated that Resident A could stay in the home if there were small improvements.

On February 8, 2022, I conducted an unannounced on-site investigation and made face to face contact with Mr. Maxson, Licensee Designee, Employee #1, Home Manager #1, Nurse #1, Resident A, along with other staff and residents.

Regarding the eviction notice, Mr. Maxson informed me that prior to receiving the notice, Resident A was refusing showers and not letting staff into her room to be cleaned. They usually shower the residents, clean their rooms, and do laundry on the same day. According to Mr. Maxson, Resident A had just refused the daily living assistance and a minute later, Home Manager #1 overheard her on the phone complaining that staff would not give her a shower. Home Manager #1 stated to Resident A that she knew that was not true and that she had refused her shower. Later that evening, Mr. Maxson spoke with Resident A about the problems, stating "We can't do this anymore." He first gave Resident A the verbal notice, then followed up in writing. He agreed to provide me with a copy of the written discharge notice.

Mr. Maxson also recalled that Resident A wants others to hear her conversation so she would often talk loudly on her cell phone in the dining area. He stated that Resident A can be disruptive to other residents. Resident A has been asked not to bring her cell phone to the dining room. He also stated that when Resident A's daughters visit the home, they refuse to enter through the front door (where they complete COVID-19 screening). Resident A will let them in the side door instead. Mr. Maxson stated that around the holidays, he forgives others and had talked with Resident A and her family, offering to start over. Mr. Maxson stated that he has taken good care of Resident A, and he has received no appreciation.

While I was at the facility, I interviewed Resident A. She informed me that Mr. Maxson evicted her in December because she was not polite to the employees, and she was taking pictures in the common areas of the home. She informed me that was not true. Resident A also informed me that Mr. Maxson said, "You're out of here!"

On February 8, 2022, I spoke to Home Manager #1 and Nurse #1. The information Home Manager #1 reported was consistent with what Mr. Maxson had reported. In

addition, I spoke to Nurse #1 who stated that Resident A had visitors on her birthday. Nurse #1 witnessed staff trying to clean Resident A's room, but she was refusing. A family member asked Resident A if she did this (refused assistance) and Resident A said that she did. According to Nurse #1, the family member then said, now they could see where the issues were coming from.

I encouraged Mr. Maxson and his staff to document refusals in the case record, for future reference.

As a part of this investigation, I reviewed the "*Residence Involuntary Discharge Notice*." It was noted that the 30-day discharge notice was being provided because Resident A had a bad attitude towards staff, the owner, and residents. In addition, that she was using her cell phone to take pictures in the common areas of the home, without permission of others. The document was dated for December 3, 2021.

FM #1 later informed me that she texted Mr. Maxson on December 9, 2021, regarding her mother being told she was evicted on December 3, 2021, and she had not received anything in writing at that point.

APPLICABLE RULE	
R 400.15302	**Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.**
	(3) A licensee shall provide a resident and his or her designated representative with a 30-day written notice before discharge from the home. The written notice shall state the reasons for discharge. A copy of the written notice shall be sent to the resident's designated representative and responsible agency. The provisions of this subrule do not preclude a licensee from providing other legal notice as required by law.

ANALYSIS:	Mr. Maxson gave Resident A the verbal notice, regarding discharging her from the home on December 3, 2021. He later followed up in writing. The 30-day discharge notice was dated for December 3, 2021. FM #1 stated that on December 3, 2021, Mr. Maxson stood by her mother's door and stated, "You're out of here, you have 30-days." FM #1 received the written discharge notice during the second week of December, and the written 30-day notice was dated for December 3, 2021. While it's unclear if the discharge notice was backdated, or if it was delayed for some other reason, what is clear is that the 30-day discharge notice was provided sometime early in December, and Resident A remains in the home. As of the date of this report, this timeframe has exceeded the written 30-day notice provided. Based on the information gathered during this investigation and provided above, it's concluded that there is not a 51% preponderance of the evidence to support the allegations that the 30-day written discharge notice was not properly provided as required.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATIONS:

There were several times when Resident A was not given medication the doctor ordered, and the staff have lost Resident A's medication.

INVESTIGATION:

On February 8, 2022, I spoke to FM #1 about the medications. She stated that six years ago, her mother had MRSA and was septic. The doctor finally agreed to give her new knee replacements (a total knee revision). The procedures were scheduled for six weeks apart, and they occurred in June and August of 2021. The first procedure was on June 14, 2021, and the second procedure was on August 6, 2021.

On June 14, 2021, FM #1 met with Resident A around 9:30 a.m. for surgery. Prior to the procedures, facility staff were told to give Resident A the blood pressure medications before the surgery. According to FM #1, they only gave her one of the blood pressure medications, Norvasc (Amlodipine), and did not give her the beta blocker, Metoprolol. Resident A's blood pressure was 200/100 at the hospital.

According to FM #1, this happened on both occasions of the surgeries, in which Resident A was not given the Metoprolol. Therefore, the medication was administrated at the hospital.

On June 14, 2021, Resident A had the 1st surgery and remained in the hospital for a few days. On June 17, 2021, Resident A went to Rehab Center #1 where she remained until July 6, 2021. Resident A then returned to Grand Vista Properties.

Resident A had several follow-up appointments while she was at Rehab Center #1. She also had a follow-up appointment on July 7, 2021. According to FM #1, Resident A had an infection, and they were supposed to give her an antibiotic (Cephalexin 500mg); however, on July 9, 2021, it was discovered that they went three days without getting the antibiotic filled. According to FM #1, this was serious because Resident A had a history of MRSA and there was a concern that she would get cellulitis in her leg (which she did not).

FM #1 stated that when Resident A was discharged from Rehab Center #1 in July, she had a list of prescriptions. The facility staff was provided with a copy of the orders. When FM #1 went to the facility, a direct care staff found the medications in the bottom of the medication cart; however, they said they could not administer the medications because the information was not in the computer. FM #1 stated that she spoke to the nurse (who no longer works for the facility), and the nurse told her that the medications were showing in the computer in that building (Grand Vista Properties II) but not in the computer for Grand Vista Properties (I), where Resident A was admitted.

FM #1 stated that facility staff don't read the doctor's orders, and there was a lack of communication between the visiting Nurse Practitioner #1 and staff.

On August 6, 2021, Resident A had her second surgery, and she was discharged to Rehab Center #1 on August 10, 2021. Resident A returned to Grand Vista Properties on August 18, 2021.

On August 31, 2021, Resident A was seen by her doctor. Resident A was experiencing pain in her leg. There was a concern that she had a blood clot. An ultrasound and X-rays were supposed to be completed; however, that didn't happen. So, they (FM #1) ended up taking Resident A to the emergency room in Battle Creek to get an ultrasound. It was determined that she did not have a blood clot. FM #1 also learned that Resident A was not taking her Aspirin because she had run out. FM #1 also ended up purchasing the Aspirin and delivering it to the facility.

FM #1 also recalled that in September of 2021, Resident A was wheezing, and her legs were swollen. Resident A needed to get rid of the fluid. Nurse Practitioner #1 (who goes to the facility to see the residents) ordered Lasix (Furosemide) on 09/21/21, but Resident A was not receiving the medication. On 9/29/21, FM #1 went and picked up the prescription and brought it to the facility staff. It should be noted

that the medication was originally sent to the wrong pharmacy, but FM #1 stated that the staff should have followed up regarding the prescription.

I inquired about the lost medications and FM #1 stated there was one lost pill. In addition, that her mother had two dental procedures, and she was supposed to have the medication Cephalexin 500 mg, (one pill one hour before the procedure and one pill two hours after the procedure). On December 5, 2021, Resident A had a procedure and used two of the four pills. On December 15, 2021, Resident A had the second dentist appointment, and she was given one of the pills before the procedure, but they lost the pill for after the procedure; therefore, FM #1 had to get the prescription filled to provide the pill they lost. According to FM #1, this wasted a refill, and she still has three pills left.

FM #1 later sent me a picture of the medication container and information. It was noted that the Cephalexin 500 mg was last filled on December 15, 2021, quantity 4.

Overall, FM #1 stated that facility staff don't communicate with her or return her phone calls. She often does not learn that a medication is needed until after the medication is gone. In addition, she is not promptly informed about matters regarding her mother.

On February 8, 2022, I inquired about Resident A not being given her blood pressure medications before the surgeries, and Mr. Maxson stated that the previous administrator would have been here, and he did not recall the situation.

On February 8, 2022, I interviewed Employee #1. She stated that Resident A went to Rehab Center #1 after her surgery. She was not aware of any missing or lost medications. Employee #1 reported that Resident A received her medications as prescribed.

During my interview with Resident A, inquired about her not getting her blood pressure medications prior to the surgeries. She confirmed that her blood pressure was high and stated that they almost didn't do the surgery, "I guess I wasn't getting my medications."

As a part of this investigation, I reviewed the Medication Administration Records for Resident A. As previously noted above, prior to the procedures, facility staff were told to give Resident A the blood pressure medications before the surgery. They only gave her one of the blood pressure medications, Norvasc (amlodipine), and did not give her the beta blocker, Metoprolol.

A review of the medication log for June 14, 2021, reflects that Resident A was given the medication, Metoprolol SUC Tab 25mg, at 8:44 a.m. and the medication, Norvasc (amlodipine), was not listed on the MAR.

FM #1 provided a medical record (on 02/11/2022), documenting that the Norvasc (amlodipine), was prescribed on June 17, 2021. Of the records provided and reviewed, there is no indication that this medication was prescribed prior to this date.

Resident A returned to the facility from Rehab Center #1 on July 6, 2021. As related to this issue, the medication records reflected that staff resumed passing some of her medications on July 6, 2021. It was noted that the Norvasc (Amlodipine) 5mg, was not administered on July 7, and 8. Resident A was administered the medication Norvasc (Amlodipine) on July 9, 2021, and going forward, with the exception of when staff documented that she was out of the home.

As noted above, according to FM #1, Resident A had an infection, and they were supposed to give her an antibiotic (Cephalexin 500mg); however, on July 9, 2021, it was discovered that they went three days without getting the antibiotic filled. The MAR reflected that the medication was first administered on July 8, 2021, at 9:13 p.m. and documented during the 8:00 p.m. medication pass.

Regarding the Aspirin, it was noted on the MAR Notations that this medication was not passed on the following dates: July 7, 8, 9, 11, 12,13, 15, 16, 17, 18, 19, 20,21 and 26, as staff noted that the medication was not in the medication cart.

I reviewed the medication logs for September of 2021 and noted that the Lasix (Furosemide) was administered beginning on September 29, 2021, at 8:00 a.m.

It was also noted that for the month of September, Resident A was prescribed and given Aspirin 81mg, twice daily, and Amlodipine 5mg (once daily).

On February 14, 2022, I spoke with Mr. Maxson, Licensee Designee, as I had some follow up questions. I informed him that it appeared that there was a breakdown in communication between the facility staff and the family. He informed me that Resident A's daughters don't get along. In addition, that Resident A may not be telling them the truth, and everyone is on a different page. Regarding the missing medications, Mr. Maxson stated that it would depend on if the facility staff were responsible for getting the medications or if the family was responsible for getting the medications. He stated that one pharmacy only fills the prescription once a month, with a 30-day supply, and Resident A's family likes to get the 90-day supply to save on the co-pays. I asked him about Resident A not receiving the Aspirin, as staff noted that it was not in the cart. He stated that Resident A's family likes to go to Walmart and purchase the bottles instead of it being filled through the pharmacy. He stated that that can't give the medication if they don't have it. I inquired if there was any documentation to demonstrate that they contacted the family to inform them about being out of the medications. He informed me that he would have to check into the matter and follow-up with me. I also inquired about the missing pill after the dental procedure on December 15, 2021, and Mr. Maxson stated he would have to check into the at matter as well.

Mr. Maxson called and informed that the family did not supply the Aspirin, it was not supplied so it could not be administered. Regarding the (Cephalexin 500 mg), that was missing on December 15, 2021, Mr. Maxson stated they were never supplied with that medication from the family; and they don't show this medication in the system on that date. Therefore, they did not administer the medication.

On February 14, 2022, I spoke with FM #1 regarding the missing medication. According to FM #1, Resident A received the first pill before her dental procedure. FM #1 stated that after the dental procedure, her mother called and said that they did not have the pill that she was supposed to have after the procedure. FM #1 then went to the pharmacy and had the prescription filled. She took the medication to her mother's room and gave the medication to her (Resident A). I inquired if the facility staff were aware that Resident A received the medication that she gave. FM #1 could not recall if they were informed or notified. At that point, she just wanted to make sure her mother received the medication.

On February 14, 2022, I conducted the exit conference with Mr. Maxson. I also inquired about the protocol regarding ordering the medications when the family is responsible for purchasing the medications. Mr. Maxson stated that they usually call, two to three days before the medication runs out and request the refill. He stated that they run into issues, for example they have two prescriptions now that have run out and they have called to have the family refill the medication. I recommended providing notice at least one week before medications run out. Mr. Maxson stated that Home Manager #1 told him that the family is often tardy with getting Resident A's medications filled, which is why they prefer to utilize one pharmacy. Mr. Maxson expressed concerns and stated that due to the communication issues with this family, he's being set up to fail. During this conversation, I made some recommendations regarding the facility protocols and procedures. I also informed Mr. Maxson that regardless of who is responsible for getting the medications, he is responsible to ensure that the resident receives their medication as prescribed, and he should document efforts and contacts when completing the process. Mr. Maxson and I also reviewed the medication logs. I explained the findings and my recommendations. Mr. Maxson agreed to submit a written corrective action plan to address the established violation.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.

ANALYSIS:	According to the MAR, the Norvasc (Amlodipine) 5mg, was not administered on July 7, and 8. Regarding the Aspirin, it was noted on the MAR Notations that this medication was not passed on the following dates: July 7, 8, 9, 11, 12,13, 15, 16, 17, 18, 19, 20,21 and 26, as the medication was not in the medication cart. Regarding the lost medication, FM #1 sent me a picture of the medication container and information. It was noted that the Cephalexin 500 mg was last filled on December 15, 2021, quantity 4. Based on the information gathered during this investigation and provided above, it's concluded that there is a preponderance of the evidence to support the allegations that Resident A was not given her medications as prescribed.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATIONS:

Allegations that staff were told not to talk to Resident A and to feed her last. Resident A is isolated.

INVESTIGATION:

During the course of this investigation, it was also alleged that staff were told not to talk to Resident A and to feed her last. In addition, that Resident A is isolated.

On February 8, 2022, I spoke with FM #1. She informed me that the residents were not allowed to go into each other's rooms and the lady (Resident B) across the hall was not eating. FM #1 stated that her mother was just trying to look out for the lady (Resident B), as she did not have her Ensure (meal supplement). In addition, that her mother is being isolated, as they were told not to talk to her, and they won't let her sit with Resident B at the lunch table anymore.

On February 8, 2022, I interviewed Mr. Maxson. He denied that staff were told not to talk to Resident A or that she was intentionally served last. He stated that residents that are sitting in the dining room are served first and then those who remain in their rooms are served after them. He also explained that Resident A, Resident B and Resident C, would sit together in the dining room and they were a "tough group." He has heard that there were complaints of them being served last. He also recalled that breakfast is cooked to order, so depending on what time they arrive to the dining

room and place their orders, is when they're served. Mr. Maxson stated that he has some residents that are constant complainers. He stated there is "nothing I can do to make them happy."

Mr. Maxson and I discussed Resident B and her progress. He denied that she was being starved. He informed me that she has had some rough times, due to her health issues, and she has recently been put on hospice. He stated that she receives good care in the home. He also has regular contact with her power of attorney. While at the facility, I reviewed the weight records for Resident B and noted that she only maintained or gained weight.

During my on-site investigation (on 02/08/2022), I arrived at the facility just before lunch. The staff were not wearing masks. I observed several residents sitting in the dining area. I observed the staff preparing the meals and serving the residents. Resident A was sitting at a table with a male resident (name unknown). Their (Resident A and unknown resident) meals were not served last. I also observed the staff interacting and talking to the residents.

Mr. Maxson reported that he has taken good care of Resident A, and he recently reduced the levels of care for her. He denied that she is generally isolated to her room. He stated the only time she has been isolated is when there was a possible COVID-19 exposure, positive Covid in the home, and or quarantining was required per the CDC guidelines. I also inquired why the staff were not wearing masks, and Mr. Maxson stated that the information changes so frequently, and he was of the impression that they were not required. I informed him that I would forward him the link to the information regarding the mask requirements in adult foster care homes.

On February 8, 2022, I interviewed Resident A. We discussed the food and she stated there was "much to be desired" as they served too much macaroni and creamed styled corn. I asked about the mealtimes and how residents were served, and she stated that the woman's table was served first, then the men. Resident A stated, "I'm an odd ball," and her friends used to come to lunch more but now they don't. We discussed her friend, Resident B. Resident A reported that she (Resident B) was more alert lately.

I inquired about her being isolated and Resident A informed me that she was only in her room when there were issues related to COVID-19. Regarding the staff, Resident A informed me that there are different girls working in the home all the time, and there was not much consistency with employees. Resident A was concerned that perhaps the staff were not paid enough. I observed several packed boxes in Resident A's room. She reported that she was moving.

During my interview with Employee #1, she reported that the residents in the dining room are served first, then the residents who remained in their rooms are served. She did not confirm that staff were not to talk to Resident A or to serve her meals

last. Regarding isolation, the only time residents remained in their rooms were during times when there were positive COVID cases in the home.

It should also be noted that during my follow up contacts with FM #1, she also informed me that her mother fell out of bed on September 28, 2021. Her mother reported to her that she fell out of bed with her legs out. Resident A also informed FM #1 that they called Mr. Maxson and Home Manager #1 to put her back into bed. This happened around 5:00 a.m. FM #1 was not contacted regarding this matter.

On February 14, 2022, I inquired about this incident and Mr. Maxson stated that Resident A did not fall. Resident A was very weak from having knee surgery and she slid down when attempting to get up to go to the bathroom. Her legs gave way as they did not support her. Mr. Maxson stated that he did not call the family because it was not a fall. Resident A did not have any bumps or bruises.

Mr. Maxson spoke to Home Manager #1, and she also recalled the incident. Resident A had a slipcover on her bed, and she slid down the mattress. They assisted her back into bed. Mr. Maxson stated that they asked if she wanted them to write a report and Resident A stated that she just slipped. According to Mr. Maxson, Resident A was embarrassed when the slip occurred.

On February 14, 2022, Family Member #2 (FM #2) contacted me as she wanted to discuss what she had witnessed at the facility. FM #2 stated that during the mealtime she observed the staff leaving the area, and she was concerned that a resident could choke. She also stated that when the staff were away, that one resident wanted coffee and another wanted lemonade, so she got the beverages for them. I explained that while it’s not a good idea for the staff to leave the residents in the dining room, the staff are on the premises and in the area; and that the level of supervision is based on each individual resident. If there is a resident who requires line of sight while eating, then staff would be required to sit with that resident during mealtimes. I also explained that each resident has a kitchenette in their room, and they may have snacks, on their own, in their room. Overall, staff are to monitor residents on a regular basis to ensure their safety.

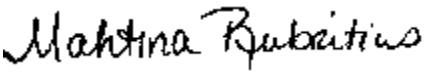
FM #2 also explained that when she pulled up to the facility to take her mother to see the Christmas lights, about four staff were in the office with the door closed; however, when they saw that she arrived they dispersed.

FM #2 also informed me that she observed the side door alarm not to be functioning correctly, as the battery would be removed etc. I explained to her that the door alarm is not required. In addition, that the door alarm is not to take the place of staff supervision. Staff are to regularly monitor the residents based on their assessed needs.

APPLICABLE RULE	
R 400.15305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Mr. Maxson denied that staff were told not to talk to Resident A or that she was intentionally served last. During my on-site investigation, I observed the lunch mealtime and did not observe Resident A to be served last. I also observed the staff interacting and talking to the residents. Resident A stated that the woman's table was served first, then the men. During my interview with Employee #1, she reported that the residents in the dining room are served first, then the residents who remained in their rooms are served. Mr. Maxson, Resident A, and Employee #1 report that residents remained in their rooms only when there were issues related to COVID-19. Based on the information gathered during this investigation and provided above, it's concluded that there is not a preponderance of the evidence to support the allegations that Resident A was not treated with dignity and her personal needs, including protection and safety, were not attended to at all times in accordance with the provisions of the act.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable written corrective action plan, I recommend no change to the status of the license.



02/14/2022

Mahtina Rubritius Date
Licensing Consultant

Approved By:

02/15/2022

Ardra Hunter Date
Area Manager