GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 15, 2022

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

RE: License #: AL130363312
Investigation #: 2022A1024033
Grand Vista Of Marshall

Dear Mr. Burritt:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

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 (616) 356-0183.

Sincerely,

Ondrea Johnson

Ondrea Johnson, Licensing Consultant
Bureau of Community and Health Systems
427 East Alcott
Kalamazoo, MI 49001

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL130363312
Investigation #:	2022A1024033
Complaint Receipt Date:	05/23/2022
Investigation Initiation Date:	05/25/2022
Report Due Date:	07/22/2022
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
Facility Address:	208 Winston Drive Marshall, MI 49068
Facility Telephone #:	(517) 227-4055
Original Issuance Date:	06/15/2016
License **Status:**	REGULAR
Effective Date:	12/15/2020
Expiration Date:	12/14/2022
Capacity:	20
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident A's call light is not answered in a timely manner by staff members.	No
Staff gave Resident A the wrong amount of methadone.	No

III. METHODOLOGY

05/23/2022	Special Investigation Intake 2022A1024033
05/25/2022	Special Investigation Initiated – Telephone with Relative A2
05/26/2022	Contact - Telephone call received with Relative A1
07/01/2022	Inspection Completed On-site with direct care staff member Kelly Windfiey and Alexis Griffin
07/01/2022	Contact - Telephone call made with licensee designee Dustin Burritt
07/08/2022	Contact - Telephone call made with nurse Erica Burritt and direct care staff member Jordan Clemens
07/09/2022	Contact - Document Received Review of Resident A's Medication Administration Record (MAR)
07/12/2022	Contact-Telephone call made with Centrica Care Navigators Hospice home care manager Marcella Beard
07/12/2022	Exit Conference with licensee designee Dustin Burritt

ALLEGATION:

Resident A's call light is not answered in a timely manner by staff members.

INVESTIGATION:

On 5/23/2022, I received this complaint through the Bureau of Community and Health Systems (BCHS) online complaint system. This complaint alleged Resident A's call light is not answered in a timely manner by staff members.

On 5/25/2022, I conducted an interview with Relative A2 who stated she visits Resident A regularly and stays overnight with Resident A occasionally as Resident A does not like being alone. Relative A2 stated she believes direct care staff members do not respond to Resident A in a timely manner as Resident A has waited hours before direct care staff will respond to Resident A's call light. Relative A2 stated she has observed direct care staff members sitting at the nursing station in the facility on their phones and reading magazines while Resident A's call light goes without being answered.

On 5/26/2022, I conducted an interview with Relative A1 who stated that Resident A has been living in the facility for about three months and Relative A1 has stayed the night with her mother every night because Resident A does not feel safe living in a community setting. Relative A1 stated during the day she noticed direct care staff members do not respond to Resident A's call light as promptly and Resident A has waited at least 30 minutes before direct care staff members will respond to her. Relative A1 stated direct care staff members on the 2nd shift and 3rd shift "are wonderful" however the nurse who works during the day seems to be often irritated. Relative A1 stated there are three direct care staff members that work during the day therefore staff members should be able to respond to Resident A's call light more promptly but instead she has observed them reading magazines or on their phone. Relative A1 stated Resident A is diagnosed with Dementia and participates in hospice services therefore there is a hospice nurse that comes out weekly. Relative A1 further stated she hired a private sitter to sit with Resident A in her bedroom when Relative A1 and Relative A2 are not able to visit as Resident A will get anxiety if she is alone in her bedroom. Relative A1 stated Resident A has been asked by Mr. Burritt to find alternative placement therefore they are relocating Resident A to another facility today (05/26/2022). Relative A1 further stated Relative A2 was asked to leave the facility immediately as Relative A2 had a bed bug infestation in her home and brought the bed bugs to the facility.

On 7/1/2022, I conducted an onsite investigation at the facility with direct care staff members Kelly Windfiey and Alexis Griffin who both stated they worked regularly with Resident A and have witnessed Resident A use her call light about every 10 minutes to request for a staff member to "sit with her" on a regular basis. Ms. Windfiey stated she has tried to encourage Resident A to come out to the common areas to be around the other residents however Resident A refused and preferred to stay in her room. Ms. Windfiey and Ms. Griffin both stated they have no knowledge of any direct care staff member not tending to Resident A's needs in a timely manner and believe Resident A's call light was answered within 5 to 10 minutes at the latest each time the call light was used by Resident A.

On 7/1/2022, I conducted an interview with licensee designee Dustin Burritt. Mr. Burritt stated Resident A was admitted to the facility at the end of February 2022 and discharged at the end of May 2022. Mr. Burritt stated he had ongoing issues with Resident A and her representatives as they had unrealistic expectations of what should be provided in an adult foster care setting after Resident A moved in. Mr.

Burritt stated the unrealistic expectation pertained to Resident A wanting someone to sit with her at all times because she did not want to be by herself in her bedroom and Resident A's representatives expected this. Mr. Burritt stated Resident A's representatives often made false accusations about him and other direct care staff members and would complain if a staff member did not answer Resident A's call light within seconds of its use. Mr. Burritt stated all direct care staff members attended to Resident A's needs at all times and Mr. Burritt explained to Resident A and her representatives the facility was not able to have a staff member sit with Resident A 24/7 however encouraged Resident A to come out of her bedroom in the common areas to be around other residents and staff. Mr. Burritt stated Resident A had a relative or a hospice worker visiting with her regularly therefore Resident A was often with someone while residing at the facility. Mr. Burritt further stated the family also hired a private worker to sit with Resident A when Resident A's relatives were not able to do so. It should be noted Mr. Burritt contacted me on 5/24/2022 to inform me that he was going to provide Resident A with a 48 hour discharge notice due to ongoing issues with Resident A's representatives demand for 1:1 staffing in order for Resident A to have a "sitter at Resident A's bedside 24/7", Resident A and her representatives brought in bed bugs into the facility, and the relatives continued to visit and spend the night with Resident A without providing proof that the bed bug infestation at their home had been treated to avoid further incidents of the infestation of bed bugs.

On 7/8/2022, I conducted an interview with nurse Erica Burritt and direct care staff member Jordan Clemens regarding this allegation. Ms. Burritt stated Resident A is related to her daughter and she has known Resident A for many years. Ms. Burritt stated Resident A pushed her call light button every 5 minutes and expected someone to sit by her side 24/7 therefore staff members were often in Resident A's bedroom because she pushed her call button regularly. Ms. Burritt stated a hospice home help aid came out to the home 2 to 3 times a week and Resident A had family members with her everyday who eventually hired a sitter to sit with Resident A regularly. Ms. Burritt stated Resident A received more attention than any other resident in the home and she and her representatives still made complaints that were not warranted. Ms. Burritt stated she worked with Resident A regularly and believes Resident A was attended to at all times. Ms. Burritt further stated to her knowledge the latest a staff member has responded to Resident A's call light button was within 10 minutes.

Ms. Clemons stated she is related to Resident A and has known Resident A her entire life. Ms. Clemons stated Resident A often had family members visiting with her and Relative A1 often wanted a staff member to sit with Resident A in her bedroom 24/7. Ms. Clemons stated she informed Relative A1 and Relative A2 that staff was unable to sit with Resident A in her bedroom however Resident A still used her call light every 10 minutes to ask for this request. Ms. Clemons stated she enjoyed spending time with Resident A and all the staff members loved interacting with Resident A. Ms. Clemons stated she has no knowledge of Resident A's call light not being answered within 5 minutes.

On 7/12/2022, I conducted an interview with home care manager Marcella Beard from Centrica Care Navigators who stated that Resident A participated in hospice services that required hospice workers to go out to the facility regularly. Ms. Beard stated she has no reports or complaints regarding staff members not providing adequate care or attending to Resident A's needs in a timely manner.

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:	Based on my investigation which included interviews with direct care staff members Kelly Windfiey, Alexis Griffin, Jordan Clemons, nurse Erica Burritt, licensee designee Dustin Burritt, Relative A1 and A2 there is no evidence to support the allegation Resident A's call light was not answered in a timely manner by staff members. Ms. Windfiey, Ms. Griffin, Ms. Jordan, Ms. Burritt and Mr. Burritt all reported direct care staff responded to Resident A's call light within 5 to 10 minutes and Resident A used her call light button regularly to request for a staff member to sit with her. These staff members also stated that hospice workers, relatives and private workers visited with Resident A regularly therefore someone was always with Resident A while she resided at the facility. Ms. Beard stated she has not had any reports of staff members not attending to Resident A in a timely manner. Resident A's personal care needs, including safety and protection, has been attended to at all times.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Staff gave Resident A the wrong amount of methadone.

INVESTIGATION:

This complaint also alleged that staff game Resident A the wrong amount of methadone.

On 5/26/2022, I conducted an interview with Relative A1 who stated while visiting with Resident A she often observed staff administer medications to Resident A. Relative A1 stated recently she observed a direct care staff member attempt to

administer Resident A 10ml of methadone when she was supposed to take 1ml of methadone. Relative A stated she tried to tell the direct care staff member that the medication amount had been changed however the staff member would not listen to her.

On 7/1/2022, I conducted an onsite investigation at the facility with direct care staff member Kelly Windfiey and Alexis Griffin who both stated they have administered medications to Resident A and have not observed any staff member giving the wrong amount of any medication to Resident A nor had this information been reported to them. Ms. Windfiey and Ms. Griffin also both stated Resident A has not had any issues with her medications while residing at the facility.

On 7/1/2022, I conducted an interview with licensee designee Dustin Burritt who stated that he has not had any reports of staff administering the wrong dosage amount for any of Resident A's medications. Mr. Burritt stated he has a personal connection with Resident A and he believes Resident A's representatives attempted to slander his name by making false accusations against him and his staff members.

On 7/8/2022, I conducted an interview with nurse Erica Burritt and direct care staff member Jordan Clemens who both stated that they have administered medications to Resident A during the three months she resided in the facility and they have no knowledge of any staff member administering the wrong dosage amount for any of Resident A's medications. Ms. Burritt stated Resident A took her methadone daily without incident and took all of her medications without any issues. Mr. Burritt stated Resident A's medications were prescribed by Centrica Care Navigators Hospice who also monitored Resident A's medications by a nurse who came out to the home twice a week.

On 7/9/2022, I reviewed Resident A's Medication Administration Record (MAR) for the months of March 2022, April 2022, and May 2022. According to this record, Resident A was prescribed Methadone 5mg solution and Methadone 10mg oral concentration. I did not observe any medications errors in this record. It should be noted there is no record of Resident A being prescribed Methadone 1mg.

On 7/12/2022, I conducted an interview with home care manager Marcella Beard from Centrica Care Navigators Hospice who stated she has not received any reports or complaints regarding Resident A receiving the wrong dosage amount for her medications.

APPLICABLE RULE	
R 400.15312	**Resident medications**
	(1) Prescription medications, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescriptions 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:	Based on my investigation which included interviews with direct care staff members Kelly Windfiey, Alexis Griffin, Jordan Clemons, nurse Erica Burritt, licensee designee Dustin Burritt, and Relative A1 along with a review of Resident A's medication administration record, there is no evidence to support the allegation staff gave Resident A the wrong among of methadone. Ms. Windfiey, Ms. Griffin, Ms. Burritt, Mr. Burritt all have no knowledge of Resident A being administered the wrong dosage amount of any her medications and reports that Resident A had no issues taking her medications. According to Resident A's MAR, Resident A was prescribed Methadone 5mg solution and Methadone 10mg oral concentration, there was no prescription for 1mg dose of Methadone. I did not observe any medications errors in this record.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 7/12/2022, I conducted an exit conference with licensee designee Dustin Burritt. I informed Mr. Burritt of my findings and allowed him an opportunity to ask questions or make comments.

IV. RECOMMENDATION

I recommend the current license status remained unchanged.

Ondrea Johnson 7/12/2022

Ondrea Johnson Date
Licensing Consultant

Approved By:

Dawn Timm 07/15/2022

Dawn N. Timm Date
Area Manager