GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 2, 2023

Joellen Deilus
3721 Indian Trail
China, MI 48054

RE: License #: AM740389877
Investigation #: 2023A0580025
Visions AFC

Dear Ms. Deilus:

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 (517) 643-7960.

Sincerely,

Sabrina McGowan, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 835-1019

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM740389877
Investigation #:	2023A0580025
Complaint Receipt Date:	03/07/2023
Investigation Initiation Date:	03/10/2023
Report Due Date:	05/06/2023
Licensee Name:	Joellen Deilus
Licensee Address:	3721 Indian Trail China, MI 48054
Licensee Telephone #:	(586) 381-4218
Administrator:	Jennifer Yielding
Licensee Designee:	N/A
Name of Facility:	Visions AFC
Facility Address:	868 N Carney Dr St Clair, MI 48079
Facility Telephone #:	(810) 326-1688
Original Issuance Date:	02/28/2018
License **Status:**	REGULAR
Effective Date:	08/31/2022
Expiration Date:	08/30/2024
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED MENTALLY ILL ALZHEIMERS

	AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Residents are neglected by night shift, left in chairs all day and in wet clothes or underwear and diapers. Some residents have pressure ulcers from general neglect.	No
Resident A was ripped from bed and had bruises of unknown detail all over.	No
Residents B has a bed infection in her left leg that is not being treated.	Yes

III. METHODOLOGY

03/07/2023	Special Investigation Intake 2023A0580025
03/10/2023	APS Referral A referral was made to APS sharing the allegations.
03/10/2023	Special Investigation Initiated - Letter This SIR was initiated by making a referral to APS.
03/21/2023	Inspection Completed On-site An onsite inspection was conducted at Visions AFC.
03/21/2023	Contact - Face to Face Spoke with direct staff, Ms. Charlotte McFadden.
03/21/2023	Contact - Face to Face Spoke with direct staff, Ms. Leihla Arnett.
03/21/2023	Contact - Face to Face Spoke with direct staff, Ms. Jerri Enders.
03/21/2023	Contact - Face to Face An observation of Resident A was conducted.
03/21/2023	Contact - Face to Face Interview with Resident B.
03/21/2023	Contact - Face to Face Interview with Resident C.

03/21/2023	Contact - Face to Face Interview with Resident D.
03/21/2023	Contact - Face to Face Spoke with Resident E and Relative Guardian E.
03/30/2023	Contact - Telephone call received A call was received from the licensee, Ms. Delius.
04/05/2023	Contact - Telephone call made Spoke with Ms. Jennifer Yielding, Manager.
04/07/2023	Contact - Document Received Email of documents requested received.
04/25/2023	Contact - Telephone call made Call to Relative Guardian B.
04/25/2023	Contact - Telephone call made Call to Relative Guardian A.
04/26/2023	Contact - Document Received Email of document requested received.
05/01/2023	Exit Conference An exit conference was held with the licensee designee, Ms. Deluis.

ALLEGATION:

Residents are neglected by night shift, left in chairs all day and in wet clothes or underwear and diapers. Some residents have pressure ulcers from general neglect.

INVESTIGATION:

On 03/07/2023, I received a complaint via BCAL Online complaints. On 03/10/2023, I made a referral to APS sharing the allegations alleged in this complaint.

On 03/21/2023, I conducted an unannounced onsite inspection at Visions AFC. During the interview with direct staff, Ms. Charlotte McFadden, she denied that residents are left in wet briefs. She stated that resident checks are done every 2 hours. She adds that at night some of the residents do not like to get up to have their brief changed. Staff will then change the residents while in bed. She was able to confirm that Resident B does have a bed sore on her bottom. She recently received medical wound care.

On 03/21/2023, while onsite, I spoke with direct staff, Ms. Leihla Arnett, who denied residents being left in urine.

On 03/21/2023, while onsite, I spoke with direct staff, Ms. Jerri Enders. She indicated that she has worked at the home for 12 years. None of the residents have complained about 3rd shift staff or having been left in urine.

On 03/21/2023, while onsite, I interviewed Resident B. She stated that she has had the bed sore for about 1 month. Resident B stated that initially did not want the wound care service because the wound was not broken. She stated that she has since changed her mind and is currently receiving wound care. She denied any concerns with staff response times, residents being left in urine, or residents being mistreatment by staff.

On 03/21/2023, while onsite, Resident C stated that she is treated good and has no complaints about the facility or how she is treated. She stated that she may have to wait for staff for a brief period, which, in her opinion is understandable. She adds that she receives assistance with changing her briefs as needed.

On 03/21/2023, while onsite, Resident D stated that she has no concerns with staff or their response times. She adds that staff does not purposely neglect the residents.

On 03/21/2023, while onsite, I spoke with Relative Guardian E, who was visiting with Resident E. Relative Guardian E stated that Resident E is wet a lot and had a UTI and a yeast infection a couple of weeks ago. She has since addressed her concerns with the staff in the home. She adds that she visits with Resident E two-four times a week and as a result she often ensures that Resident E's needs are met. Resident E adds that she likes living at the home.

On 04/24/2023, I spoke with Ms. Candace Stevenson, RN, at McLaren Home Care. She stated that Resident B is currently being seen for a pressure ulcer on her buttock effective 04/07/2023. She initially refused services for the Stage 2 Pressure Ulcer; however, she has since changed her mind. Instructions were left with staff on how to care for the wound, which consists of cleaning with saline, apply Opti foam dressing and to change it every 3 days as needed for drainage. She adds that the wound on her buttock is healing appropriately.

On 04/25/2023, I spoke with Relative Guardian B. She shared that Resident B was initially independent in the area of toileting, however, as she declined, she became embarrassed and often would not request assistance from staff when needed. There was also a period of time when she was refusing care or treatment for the ulcer that formed. Resident B has since agreed and began receiving wound care treatment. She has no overall concerns regarding her care at the AFC home.

On 04/26/2023, I received a copy of the Home Health Care Certification and Plan of Care for Resident B, indicating services for both a Stage 3 Pressure Ulcer on her right

buttock, and Decubitus ankle ulcer, being provided by McLaren Home Care effective 03/18/2023.

APPLICABLE RULE	
R 400.14305	**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:	It was alleged that Residents are neglected by night shift, left in chairs all day and in wet clothes or underwear and diapers. Some residents have pressure ulcers from general neglect. Direct staff, Ms. Charlotte McFadden, Ms. Leihla Arnett, and Ms. Jerri Enders deny the allegations that residents are being neglected by night shift, left in chairs all day and in wet clothes or underwear and diapers. Residents B, C and D deny the allegations that they are neglected by night shift, left in chairs all day and in wet clothes or underwear and diapers. Resident E stated that she likes living in the home. Resident B stated that initially did not want the wound care service and has since changed her mind. She is currently receiving wound care effective 04/07/2023. Relative Guardian B stated that there was also a period of time when Resident B was refusing care or treatment for the ulcer that formed, however, she has since agreed and began receiving wound care treatment. She has no overall concerns regarding her care at the AFC home. Relative Guardian E stated that Resident E is wet a lot and had a UTI and a yeast infection, which she has since addressed with the staff in the home. The Home Health Care Certification and Plan of Care for Resident B indicated services for both a Stage 3 Pressure Ulcer on her right buttock, and Decubitus ankle ulcer, being provided by McLaren Home Care effective 03/18/2023.

	Based on the interviews with staff, residents, relative guardians and Ms. Candace Stevenson, RN, of McLaren Home Care, and the document reviewed, there is not enough evidence to support the rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A was ripped from bed and had bruises of unknown detail all over.

INVESTIGATION:

On 03/21/2023, I conducted an unannounced onsite inspection at Visions AFC. During the interview with staff, Ms. Charlotte McFadden, she stated that Resident A is in her 90's and is declining in her health, however, she has never complained that about being abused by staff.

On 03/21/2023, while onsite, I spoke with direct staff, Ms. Leihla Arnett. She denied ever having seen any staff abuse the residents.

On 03/21/2023, while onsite, direct staff, Ms. Jerri Enders denied that Resident A was ripped from the bed as alleged, adding that she is proud of the care that they provide to the residents at this home.

On 03/21/2023, while onsite, I observed Resident A while sitting in a reclining chair in the living room with other residents who were watching television. Resident A is limited in her ability to communicate. She was sleepy, however smiled when prompted with a greeting. She was adequately dressed, groomed, and appeared to be receiving proper care. No bruises were observed.

On 03/30/2023, I spoke with the licensee designee, Ms. Joellen Deilus. She stated that it is her understanding that on the day of the allegations, staff assisted Resident A by sitting her up on the bed, giving her a few minutes to gather herself, then assisted her to the restroom. At no point was she snatched from the bed as alleged.

On 04/05/2023, I spoke with Ms. Jennifer Yielding, Manager. She stated that on the day in question, she received a call from staff that Resident A was reportedly lethargic and hard to awaken. She then went to the facility to do an assessment of her symptoms. She stated that she checked her blood pressure and had her sit up on the side of the bed, giving her some time to compose herself. She and another staff then assisted her to the bathroom. She denied at any time ever ripping Resident A from the bed or causing any bruises.

On 04/25/2023, I spoke with Relative Guardian A. She stated that she has been made aware of the allegations that were made. She stated that she visits with Resident A every couple of weeks, however, she has a family friend who also has a resident in the home who keeps an extra eye out and checks on her regularly. While Resident A has had a fall and a couple of UTI's in the past, there have been no recent concerns or issues with the home, or the care Resident A is receiving. She adds that with Resident A's decline due to Dementia (or Alzheimer's), her words are garbled speech, and she no longer recognizes loved ones. She denied that Resident A has any current or past unidentified bruises while in the home.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.
ANALYSIS:	It was alleged that Resident A was ripped from bed and had bruises of unknown detail all over. Licensee, Ms. Delius, Home Manager, Ms. Jennifer Yielding and Direct staff members, Ms. Charlotte McFadden, Leihla Arnett, and Ms. Jerri Enders all the deny that residents are abused by staff. Resident A is limited in her ability to communicate. She was observed adequately dressed, groomed, and appeared to be receiving proper care. No bruises were observed. Relative Guardian A stated that there have been no recent concerns or issues with the home, or the care Resident A is receiving. She denied that Resident A has any current or past unidentified bruises while in the home. Based on the interviews with Licensee, Ms. Delius, Home Manager, Ms. Jennifer Yielding and Direct staff members, Ms.

	Charlotte McFadden, Leihla Arnett and Ms. Jerri Enders, Relative Guardian A, and an observation of Resident A, there is not enough evidence to support the rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Residents B has a bad infection in her left leg that is not being treated.

INVESTIGATION:

On 03/21/2023, while onsite, I interviewed Resident B, who stated that she hurt her ankle with her wheelchair. She did receive an X-ray, and nothing was broken. She did not want to go to the hospital. While onsite I observed Resident B while sitting in her room on her bed. She was adequately dressed and appeared to be receiving adequate supervision and care. Resident A's ankle was observed wrapped in a bandage.

On 03/30/2023, I spoke with the licensee designee, Ms. Joellen Deilus who denied the allegations. She stated that she believes one of her newer staff called in the complaint based off a text message she had received from her alleging that Resident B was not receiving proper wound care. She stated that she tried to explain to her that staff must follow medical orders for residents, however, she continued to say we should be doing more. That staff has since quit working for the facility.

On 04/05/2023, Manager, Ms. Yielding recalled that on 01/26/2023, Resident B initially wounded her ankle by running over her ankle with her wheelchair. She called McLaren Palliative care the following day, 1/27/23, requesting an x-ray. Resident A denied any outside medical treatment. Resident A received an X-Ray conducted by McLaren Palliative Care on 02/14/2023. Ms. Yielding stated that she contacted McLaren Palliative Care on 2/5/23, 2/27/23, requesting wound care services for Resident B. Once she contacted the primary physician, she discovered that a referral from the physician was needed to prior to obtaining the services needed to treat the wound. Services were switched from McLaren Palliative to McLaren Home Health Care once the referral was made. Resident B was referred to McLaren Home Health to begin wound care services. The services began 03/22/2023.

On 04/07/2023, I received an emailed copy of the X-Ray examination of Resident B's ankle, physician contact record for Resident B, and records verifying McLaren Palliative Care. The x-ray, dated 02/14/2023, revealed no acute fracture, dislocation, joint space narrowing or osseous on ether the left or right ankle. Physician contact records indicate that Ms. Yielding contacted McLaren Palliative care on 01/27, 02/5, 02/27, and 03/02, and 03/22/2023.

Resident B's records indicate that she began receiving McLaren Palliative Care for COPD and Multiple Sclerosis (MS) effective 04/28/2022. Premier Physician Care provides primary care physician. Her records also indicate that she is currently receiving wound care services effective 03/18/2023, provided by McLaren Home Health Care.

On 04/24/2023, I spoke with Ms. Candace Stevenson, RN at McLaren Home Care. She stated that Resident B is currently being seen for wound care to her ankle effective 03/18/2022. Instructions were left with staff on how to care for the wound, which consists of cleaning with saline, apply Opti foam dressing and to change it every 3 days as needed for drainage, effective 03/22/2023. She adds that wound on her ankle is healing appropriately.

On 04/25/2023, I spoke with Relative Guardian B, assigned guardian for Resident B, who stated she was made aware that her mother hurt her ankle with her wheelchair when self-transferring in January of this year. While initially it was minor, she continued to reinjure the same area to the point it became of concern. She spoke with the manager, Ms. Jennifer Yielding, who had indicated that she had put in a call to wound care for services. Meanwhile, both she and Ms. Yielding offered to take her to the hospital to have it looked at, however, she declined. Wound care began in March 2023. She has no overall concerns regarding her care at the AFC home.

On 04/26/2023, I received a copy of the Home Health Care Certification and Plan of Care for Resident B, indicating services for both a Stage 3 Pressure Ulcer on her right buttock, and Decubitus ankle ulcer, being provided by McLaren Home Care effective 03/18/2023.

APPLICABLE RULE	
R 400.14310	**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:	It was alleged that Residents B has a bad infection in her left leg that is not being treated. Resident B stated that she hurt her ankle with her wheelchair. She did receive an X-ray, and nothing was broken. She did not want to go to the hospital. The licensee designee, Ms. Deluis and home manager, Ms. Jennifer Yielding denied the allegations. Manager, Ms. Yielding stated Resident B's ankle was injured on 1/26/2023. Ms. Yielding made several phone call attempts to contact McLaren Palliative Care for Resident B. Once she contacted the primary physician, she discovered that a referral

	from the physician was needed to prior to obtaining wound care service. Ms. Candace Stevenson, RN at McLaren Home Care, stated that Resident B is currently receiving treatment for wound care to her ankle effective 03/18/2022. Relative Guardian B stated she was made aware that her mother hurt her ankle with her wheelchair when self-transferring in January of this year. She and the manager, Ms. Yielding offered to take her to the hospital to have it looked at, however, she declined. Wound care began in March 2023. She has no overall concerns regarding her care at the AFC home. Resident B injured her ankle on 01/26/2023. Resident B received an x-ray examination on 02/14/2023. Resident B did not receive immediate medical care as required. Based on the interviews with licensee designee, Ms. Deluis and home manger, Ms. Jennifer Yielding, Resident B, Relative Guardian B, Ms. Candace Stevenson, RN, of McLaren Home Care, and the documents reviewed, there is enough evidence to support the rule violation, due to Ms. Ms. Yielding's delay in obtaining immediate medical care when Resident B's ankle was injured.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 05/01/2023, I conducted an exit conference with the licensee designee, Ms. Delius. Ms. Deluis was informed of the findings of this investigation, including the requirement to complete an appropriate corrective action plan.

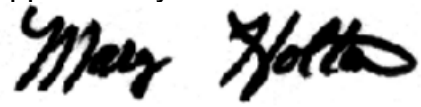
IV. RECOMMENDATION

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

May 2, 2023

Sabrina McGowan Date
Licensing Consultant

Approved By:



May 2, 2023

Mary E. Holton Date
Area Manager