GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

July 17, 2023

Eric Simcox
Landings of Genesee Valley
4444 W. Court Street
Flint, MI 48532

RE: License #: AH250236841
Investigation #: 2023A1027075
Landings of Genesee Valley

Dear Eric Simcox:

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 authorized representative 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 877-458-2757.

Sincerely,

Jessica Rogers

Jessica Rogers, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 285-7433
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH250236841
Investigation #:	2023A1027075
Complaint Receipt Date:	06/13/2023
Investigation Initiation Date:	06/14/2023
Report Due Date:	08/13/2023
Licensee Name:	Flint Michigan Retirement Housing LLC
Licensee Address:	14005 Outlook Street Overland Park, KS 66223
Licensee Telephone #:	(240) 595-6064
Administrator:	Pauline Bednarick
Authorized Representative:	Eric Simcox
Name of Facility:	Landings of Genesee Valley
Facility Address:	4444 W. Court Street Flint, MI 48532
Facility Telephone #:	(810) 720-5184
Original Issuance Date:	02/01/2001
License Status:	REGULAR
Effective Date:	03/07/2023
Expiration Date:	03/06/2024
Capacity:	114
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A was neglected. The facility was unsecure. Cameras were in resident rooms. Services should be included in resident's fees.	No
The facility was understaffed.	No
Resident A and other residents were starved.	No
The kitchen in Building 4 was unclean.	No
Additional Findings	Yes

The complainant identified some concerns that were not related to licensing rules and statues for a home for the aged. Therefore, only specific items pertaining to homes of the aged provisions of care were considered for investigation. The following items were that that could be considered under the scope of licensing.

III. METHODOLOGY

06/13/2023	Special Investigation Intake 2023A1027075
06/14/2023	Special Investigation Initiated - Letter Referral emailed to Adult Protective Services
06/14/2023	APS Referral Conducted by email
06/29/2023	Inspection Completed On-site
07/10/2023	Contact - Telephone call received Telephone interview conducted with APS worker
07/11/2023	Contact - Document Received Email received from the complainant.
07/17/2023	Inspection Completed-BCAL Sub. Compliance
08/22/2023	Exit Conference

	Conducted by voicemail with authorized representative Eric Simcox, then by email

ALLEGATION:

Resident A was neglected. The facility was unsecure. Cameras were in resident rooms. Services should be included in resident's fees.

INVESTIGATION:

On 6/13/2023, the Department received a complaint through the online complaint system which read Resident A fell due to negligence which resulted in a spine fracture. The complaint read the facility was unsecure during the day and night. The complaint read another resident had a camera in her apartment, however the camera placed in Resident A's apartment was removed without communication. The complaint read Resident A lacked assistance with shaving and weekly cleaning of her apartment.

On 6/14/2023, I emailed a referral to Adult Protective Services (APS) containing the allegations.

On 6/23/2023, the Department received a letter from APS in which the allegations were assigned for investigation.

On 6/29/2023, I conducted an on-site inspection at the facility. I interviewed administrator Pauline Bednarick who stated Resident A discharged from the facility; however, previously resided in Building 4 which was designated for assisted living residents who required lower acuity of care. Ms. Bednarick stated all residents in Building 4 required minimal or one person assistance for their care. Ms. Bednarick stated Resident A's cognition declined since her admission and she required increased level of supervision. Ms. Bednarick stated she communicated that need with Resident A's authorized representative, as well as that she should be moved to one of the higher acuity buildings. Ms. Bednarick stated Resident A did not move to a higher acuity building, so staffing was increased in Building 4 during the morning and afternoon shifts to ensure her needs were met. Ms. Bednarick stated Resident A had been hospitalized a few times while at the facility.

Ms. Bednarick stated Resident A's authorized representative provided the facility a list of people who were restricted from visiting Resident A. Ms. Bednarick stated a person on Resident A's restricted list visited her. Ms. Bednarick stated Resident A did not seem to be affected nor upset by the visit. Ms. Bednarick stated although staff monitored visitors entering the facility, they also provided resident care in which they could not visualize everyone entering the facility. Ms. Bednarick stated there were cameras in the parking lot and all side doors of the buildings were locked. Ms. Bednarick stated the front doors of each building were unlocked until midnight shift locked them around 12:00 PM, then unlocked them around 6:30 AM. Ms. Bednarick

stated each residents' apartment had a locking door for safety. Ms. Bednarick stated the midnight shift supervisor rounded on each building as well. Ms. Bednarick stated the Flint police department also randomly drove through the facility parking lot during their shifts.

Ms. Bednarick stated the facility prohibited camera use within residents' apartments. Ms. Bednarick stated if a camera was identified, she communicated with the resident's authorized representative to have the camera removed. Ms. Bednarick stated Resident A's authorized representative placed a camera in her room; however, she resided in another state, so she communicated with her that it would be removed by maintenance. Ms. Bednarick stated another resident near Resident A's apartment also had a camera in which her daughter removed it.

Ms. Bednarick stated personal assistance was provided daily by staff if the resident required assistance with tasks such as shaving. Ms. Bednarick stated each apartment was deep cleaned once weekly and staff tidied each apartment in between that time.

While on-site, I interviewed Employee #1 whose statements were consistent with Ms. Bednarick. Employee #1 stated Resident A was forgetful and asked staff what she was supposed to be doing. Employee #1 stated Resident A utilized her call pendant; however, would forget why she summoned staff. Employee #1 stated Resident A had an unsteady gait and was a fall risk, but she had not observed her fall. Employee #1 stated the buildings were secure in which there was an alarm system located on the hallway wall. Employee #1 stated resident care was provided daily consistent with each resident's service plan. Employee #1 stated light cleaning of the resident's apartment was also completed if needed.

I reviewed Resident A's History and Physical dated 8/8/2022 which read in part she had progressive weakness and debility.

I reviewed Resident A's admission contract signed by Resident A's authorized representative and dated 8/17/2022 which read in part:

> "*Landings of Genesee Valley accepts residents requiring structure, assistance with bathing, transportation, toileting, incontinence, dressing and medication management*."
>
> "*The following basic services are provided by Landings of Genesee Valley and part of the basic fee.*
>
> > *D. Assistance with activities of daily living consistent with Resident's service plan. Activities of daily living typically include assistance with bathing, dressing, grooming, toileting, reminders, wheelchair assistance, etc.*
> > *F. Daily room tidying and weekly deep clean housekeeping services."*

"Audio & Video Recording or Photographing
It is the policy of Landings of Genesee Valley that all devices designed, either by audio or video means, to monitor, records, or surveil residents in their rooms are strictly prohibited. Landings of Genesee Valley reserves the right to place video monitoring equipment in common areas. To protect the privacy rights of all residents in the facility, no resident, resident family, or guardian may place a video monitoring, recording, or surveilling device in any room of Landings of Genesee Valley. With respect to audio recording, Michigan Law provides that using any device to record upon conversations of others without consent from all parties is a felony. Landings of Genesee Valley is unable to ensure the consent from all parties that may have conversations recorded by such devices so they are prohibited."

I reviewed Resident A's face sheet which read in part she moved into the facility on 8/22/2022.

I reviewed Resident A's activities of daily living logs dated 4/1/2023 through 6/23/2023 at 4:00 PM. The logs read in part staff documented the following care was completed: morning care one person assist, oral care one person assist, safety check/toilet 9:00-11:00 AM, safety check/toilet 1:00-3:00 PM, safety check 3:00-5:00 PM, safety check/toilet 6:00-8:00 PM, evening care one person assist, safety check/toilet 8:00-10:00 PM, as well as safety checks from 10:30 PM-12:30 AM, 12:30 to 2:30 AM, 2:30-4:30 AM, and 4:30-6:30 AM. The logs read in part Resident A was "LOA" [Leave of Absence] from 4/27/2023 through the morning of 5/19/2023.

I reviewed Resident A's service plans signed as verbally communicated with her authorized representative and dated 8/22/2022 and 10/10/2022. The plans read consistent with the activities of daily living logs. The plans read in part Resident A was a fall risk, had an unsteady gait and required frequent touch assist. The plans read in part she required minimal physical assistance for dressing and grooming.

I reviewed Resident A's chart notes dated from 8/22/2022 to 6/23/2023.

Note dated 8/22/2022 read in part Resident A was able to make her needs known with confusion at times. The note read in part Resident A was a one person assist in which she utilized a walker to transfer and sometimes a wheelchair.

Note dated 9/5/2022 read in part Resident A was observed on the floor and her power of attorney, as well as home care agency were notified.

Note dated 9/7/2022 read in part Resident A had increased confusion and was transferred to the hospital.

Note dated 9/8/2022 read in part Resident A was admitted to the hospital for low sodium.

Note dated 9/21/2022 read in part Resident A was discharged from the hospital to a rehabilitation center.

Note dated 9/27/2022 read in part APS was at the facility to ask questions regarding Resident A's durable power of attorney (DPOA) in which they were informed she was at the rehabilitation center.

Note dated 10/6/2022 read in part Resident A arrived back to the facility from the rehabilitation center. The note read in part Resident A was confused, would forget her walker, had an unsteady gait and was a fall risk.

Note dated 10/8/2022 read in part Resident A's DPOA brought a pad alarm to be utilized.

Note dated 11/16/2022 read in part Resident A was observed on the floor and no injuries were noted.

Note dated 12/15/2022 read in part Resident A was diagnosed with a urinary tract infection (UTI) and her primary care doctor prescribed an antibiotic.

Note dated 4/26/2023 read in part Resident A complained of chest pain and was transferred to the hospital.

Note dated 5/2/2023 read in part Resident A would be transferred to a rehabilitation center after her hospitalization.

Note dated 5/19/2023 read in part Resident A returned to the facility with a small open area on her coccyx.

Note dated 5/22/2023 read in part the rehabilitation center notified the facility Resident A was positive for a UTI.

Note dated 6/6/2023 read in part Resident A chewed her food and spit it out at dinner.

Note dated 6/23/2023 read in part Resident A left the facility.

On 7/10/2023, I conducted a telephone interview with an APS worker who stated she was not able to substantiate the allegations.

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following:

	(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.
ANALYSIS:	Review of Resident A's records revealed she required staff assistance for her activities of daily living, was forgetful and at risk for falls due to her weakness. Facility records revealed staff documented Resident A's care was completed consistent with her service plan including two-hour checks, thus neglect could not be substantiated. There was insufficient evidence to support the facility was unsecure. Additionally, the facility's policy prohibits camera use in a resident's apartment. Observations of Building 4's living area, restroom, and resident's apartments revealed they appeared clean, thus there was insufficient evidence to support this allegation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The facility was understaffed.

INVESTIGATION:

On 6/13/2023, the Department received a complaint through the online complaint system which read the facility was understaffed.

On 6/14/2023, I emailed a referral to Adult Protective Services (APS) containing the allegations.

On 6/23/2023, the Department received a letter from APS in which the allegations were assigned for investigation.

On 6/29/2023, I conducted an on-site inspection at the facility. I interviewed administrator Pauline Bednarick who stated there were four buildings on campus in which Building 4 was considered low acuity for resident care. Ms. Bednarick stated residents required minimal or one person assist. Ms. Bednarick stated 16 residents currently resided in Building 4. Ms. Bednarick stated staff worked three shifts, however some staff were scheduled partial shifts. Ms. Bednarick stated there was one staff person for each shift and additional staff member assigned on 1st and 2nd

shifts. Ms. Bednarick stated staff worked partial shifts from 6:30 AM to 10:00 AM and 2:30 PM to 8:00 PM. Ms. Bednarick stated there was a designated supervisor of shift who floated from building to building in the event staff required assistance. Ms. Bednarick stated on average there was approximately 80 residents within the four buildings.

While on-site, I interviewed Employee #1 whose statements were consistent with Ms. Bednarick. Employee #1 stated residents in Building 4 required little assistance with their activities of daily living in which she felt they received good care. Employee #1 stated sometimes an additional staff member was assigned to Building 4, however if not, the shift supervisor was available if needed.

While on-site, I observed one staff member assigned to Building 4 and several staff members in Building 1. I observed the residents in both buildings appeared groomed and dressed in clean clothing.

I reviewed the staff scheduled dated from 4/27/2023 through 6/21/2023 which read consistent with statements from Ms. Bednarick. The schedules read the same staff were assigned to the same building on most weeks. For example, on first shift, Employee #1 was assigned three or four times per week to Building 4. Additionally, the schedules read there was an assigned supervisor of shift who was also designated to “float.”

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(5) The home shall have adequate and sufficient staff on duty at all times who are awake, fully dressed, and capable of providing for resident needs consistent with the resident service plans.
ANALYSIS:	Review of the staff scheduling, along with staff attestations and observations, revealed staffing assignments were consistent within each building, a designated shift supervisor was on duty and resident’s needs were met. Based on this information, this allegation could not be substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A and other residents were starved.

INVESTIGATION:

On 6/13/2023, the Department received a complaint through the online complaint system which read "*The Landings Of Genesee Valley are starving the Residents in building 4 which is Assisted Living and probably in building 1 as well as the Memory care building.*" The complaint read "*Sunday June 3rd for breakfast they served [Resident A] one chopped up scrambled egg and a piece of bread (I have a video). Her Doctor even wrote a letter because she has loss 14 lbs [pounds] in the short time she's been there."* The complaint read Resident A was "*constantly hospitalized with UTIs [Urinary Tract Infections] and low sodium level's because of poor diet.*" The complaint alleged another resident across the hallway from Resident A lost eight pounds.

On 6/14/2023, I emailed a referral to Adult Protective Services (APS) containing the allegations.

On 6/23/2023, the Department received a letter from APS in which the allegations were assigned for investigation.

On 6/29/2023, I conducted an on-site inspection at the facility and interviewed administrator Pauline Bednarick, who stated A was hospitalized in which she had lost weight while at the rehabilitation. Ms. Bednarick stated Resident A weighed approximately 112 to 114 pounds. Ms. Bednarick stated Resident A would frequently spit her food out.

While on-site, I observed 15 residents in Building 1 who appeared well nourished and seemed to enjoy their lunch meal. I observed six residents in Building 4 who also appeared well nourished. I interviewed four residents in Building 4 who each stated that they had their own personal preferences regarding food but received three meals daily with enough food.

While on-site, I interviewed Employee #1 who stated enough food was served at each meal and residents could choose alternate meal options if they did not like what was served. Employee #1 stated Resident A had a good appetite for breakfast but not always at her lunch meal. Employee #1 stated Resident A enjoyed oatmeal, toast with peanut butter, eggs, and ensure for breakfast. Employee #1 stated Resident A would spit out meat. Employee #1 stated if Resident A disliked or didn't want her lunch meal, then she would offer her oatmeal. Employee #1 stated Resident A was offered snacks throughout the day as well as had snacks provided by her family in her apartment.

While on-site, I interviewed Employee #2 whose statements were consistent with previous staff interviews. Employee #2 stated Resident A received a regular diet but was also served lactose free meals.

On 7/10/2023, I conducted a telephone interview with the APS worker who stated she observed Resident A had enough snacks in her apartment, as well as the facility

kitchen, on 6/14/2023. The APS worker stated residents appeared well nourished at that time.

I reviewed Resident A's admission contract signed by Resident A's authorized representative and dated 8/17/2022 which read in part:

> *"The following basic services are provided by Landings of Genesee Valley and part of the basic fee.*
>
> > *B. Meals – three (3) nutritionally, well-balanced meals are available each day. Snacks are also available on a reasonable basis, consistent with Resident's service plan."*

I reviewed Resident A's activities of daily living logs dated 4/1/2023 through 6/23/2023 at 4:00 PM. The logs read in part staff documented "Breakfast % set up at 8:00 AM," "Lunch % set up at 12:00 PM," and "Dinner % setup at 5:00 PM." The logs read in part staff documented the percentage setup in which read ranged from 50% to 100%. The logs read in part Resident A was "LOA" from 4/27/2023 through the morning of 5/19/2023.

I reviewed Resident A's medical records dated 8/8/2022 which read in part Resident A weighed 110.5 pounds on 8/8/2022 and had a diagnosis of "*Recurrent UTI*." The records read Resident A's weight was 112 pounds from dates 9/16/2022 -10/4/2022.

I reviewed a note from Dr. Matthew Harris M.D. dated 6/5/2023 which read in part:

> *"The above-name patient was seen in my office today for an appointment. Patient needs an increase in calories. [Resident A's] weight has a decrease in weight from 112 pounds in October of 2022 to current weight of 98 pounds. Please increase her calories and weigh at least monthly. She has no dietary restrictions and should be allowed to eat anything she wants. A good weight for patient would be at least 110 pounds."*

I reviewed the facility's weight records for Resident A which read in part the following: 1/3/2023 - 112 pounds, 2/9/2023 - 113 pounds, 4/14/2023 - 114 pounds, 5/2/2023 - Resident A was at the hospital, and 6/8/2023 – 105 pounds.

I reviewed Resident A's chart notes dated from 8/22/2022 to 6/23/2023.

> Note dated 9/8/2022 read in part Resident A was admitted to the hospital for low sodium.
>
> Note dated 12/15/2022 read in part Resident A was diagnosed with a urinary tract infection (UTI) and her primary care doctor prescribed an antibiotic.

Note dated 4/26/2023 read in part Resident A complained of chest pain and was transferred to the hospital.

Note dated 5/2/2023 read in part Resident A would be transferred to a rehabilitation center after her hospitalization.

Note dated 5/19/2023 read in part Resident A returned to the facility with a small open area on her coccyx.

Note dated 5/22/2023 read in part the rehabilitation center notified the facility Resident A was positive for a UTI.

Note dated 6/6/2023 read in part Resident A chewed her food and spit it out at dinner.

Note dated 6/23/2023 read in part Resident A left the facility.

APPLICABLE RULE	
R 325.1952	**Meals and special diets.**
	(1) A home shall offer 3 meals daily to be served to a resident at regular meal times. A home shall make snacks and beverages available to residents.
ANALYSIS:	Review of facility menus, along with staff and resident attestations, revealed three meals were served daily, as well as snacks and beverages were available. Review of facility documentation revealed Resident A's weight was 112 pounds in October 2022 and 114 pounds in April 2023, prior transferring to the hospital on 4/26/2023 for chest pain, then subsequently going to rehabilitation. Additionally, review of facility records revealed Resident A had one hospitalization for low sodium shortly after moving into the facility. Facility documentation revealed Resident A had a history of UTIs in which she was diagnosed with one UTI in December 2022, then in May 2023 while at the rehabilitation center. Thus, it could not be substantiated Resident A had low sodium or UTIs as result of her diet at the facility.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The kitchen in Building 4 was unclean.

INVESTIGATION:

On 6/13/2023, the Department received a complaint through the online complaint system which read the Building Four kitchen was "*filthy*." The complaint read there were no supplies, water, or snacks in the kitchen.

On 6/29/2023, I conducted an on-site inspection at the facility. I interviewed administrator Pauline Bednarick who stated the main kitchen was in Building 1 and food was transported to Buildings 2,3, and 4's satellite kitchens three times daily. Ms. Bednarick stated staff assigned to Buildings 2, 3 and 4 were to notify the kitchen staff if supplies or food items needed to restock their kitchens. Ms. Bednarick stated staff assigned to Buildings 2,3, and 4 were also to maintain the cleanliness of the kitchens.

While on-site, I interviewed Employee #1 whose statements were consistent with Ms. Bednarick. Employee #1 stated the kitchen in Building 4 maintained snacks for residents. Employee #1 stated if there was something not available such as a food item or supplies, then she would request the kitchen staff to provide it. Employee #1 stated she had sufficient supplies including but not limited to plates, silverware, and cups to serve the residents in Building 4 for each meal.

While on-site, I observed the Building 4 kitchen after lunch was served. I observed all food had been removed out of the warming pans and they were cleaned. I observed the countertops were cleaned. I observed clean glass plates and silverware. I observed supplies such as but not limited to glass plates, three sizes of glass bowels, plastic cups, glass coffee cups, silverware, gloves, plastic baggies, Styrofoam cups, Styrofoam containers for meals, and napkins. I observed inside the kitchen cupboards and the refrigerator which contained items such as but not limited to milk, dry cereal, milk, peanut butter, bread, yogurts, lunch meat, cheese, condiments, mixed fruit, pie, chips, canned soup, coffee, water, and a juice machine on the counter which served lemonade, cranberry, apple, and orange juices. I observed a water dispenser and coffee was available in the common area for residents and visitors.

APPLICABLE RULE	
R 325.1979	**General maintenance and storage.**
	(1) The building, equipment, and furniture shall be kept clean and in good repair.

ANALYSIS:	Staff attestations and observations revealed there were snacks, along with a sufficient number of supplies in the Building 4 kitchen to serve residents' meals. Although the Building 4 kitchen appeared worn, it was clean. Based on this information, this allegation was not substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Observations of the facility's main kitchen revealed there were residents who were prescribed therapeutic or special diets such as but not limited to mechanical soft, pureed, diabetic and bite size.

Observations revealed a weekly regular diet menu was posted. Additionally, observations revealed there was a menu with "Always Available Options" and "Therapeutic Menu Options." The Therapeutic Menu Options read in part there were four food options: grilled burger with lettuce and tomato, tossed garden salad, tuna salad plate, and an egg salad plate.

Interview with Employee #2 revealed the facility did not maintain and post therapeutic or special diet menus for the current week.

APPLICABLE RULE	
R 325.1953	**Menus.**
	(1) A home shall prepare and post the menu for regular and therapeutic or special diets for the current week. Changes shall be written on the planned menu to show the menu as actually served.
ANALYSIS:	Observations and interview with Employee #2 revealed the facility did not maintain and post therapeutic and special diet menus, thus was not in compliance with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Interview with Employee #2 revealed the facility did not maintain a meal census to include residents, personnel and visitors served.

APPLICABLE RULE	
R 325.1954	**Meal and food records.**
	The home shall maintain a record of the meal census, to include residents, personnel, and visitors, and a record of the kind and amount of food used for the preceding 3-month period.
ANALYSIS:	Interview with Employee #2 revealed the facility did not maintain a meal census, thus was not in compliance with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of this license remain unchanged.

07/21/2023

Jessica Rogers Date
Licensing Staff

Approved By:

08/21/2023

Andrea L. Moore, Manager Date
Long-Term-Care State Licensing Section