GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 17, 2022

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

RE: License #: AL120406800
Investigation #: 2022A1032001
Grand Vista Properties

Dear Mr. Maxson:

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. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0183.

Sincerely,

Dwight Forde, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616)-240-3850

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL120406800
Investigation #:	2022A1032001
Complaint Receipt Date:	03/21/2022
Investigation Initiation Date:	03/22/2022
Report Due Date:	04/20/2022
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?
Staff did not provide Resident A with medication.	No
Staff did not provide meals to Resident A.	No
Narcotics were stolen.	No
Staff did not respond to Resident A's call for assistance.	No
Resident A's room was not cleaned.	No
Additional Findings	No

III. METHODOLOGY

03/21/2022	Special Investigation Intake 2022A1032001
03/22/2022	Special Investigation Initiated - Telephone Telephone contact made with complainant
03/30/2022	Inspection Completed On-site
04/04/2022	Contact - Document Received
04/28/2022	Inspection Completed On-site
05/12/2022	Contact- Telephone Voicemail left for Hospice Nurse
05/16/2022	Contact-Telephone Voicemail left for Hospice Nurse
4/28/2022	Exit conference

ALLEGATION:

Staff did not provide Resident A with medication.

INVESTIGATION:

On 3/22/22, I interviewed the complainant by telephone. The complainant confirmed the allegation as stated. In addition, the complainant stated that Resident A did not receive as needed pain medications when she requested them from staff and staff did not treat her painful skin condition. She stated that Resident A was a resident at the home from 2/4 – 2/27/22.

On the day of my first inspection, there were approximately ten residents in the home and four staff members.

On 3/30/22, I interviewed staff member Amy Caudill at the home. Ms. Caudill reported that during Resident A's time at the home she administered medications. She stated that she is trained to pass medications. She explained that her training involved a three-day process on "Medcart" prior to being allowed to pass medications to residents. Ms. Caudill stated that Resident A came to the home with a skin condition but did not develop one while there. She stated that Resident A did in fact have prescription for a cream, but the cream was not kept on site. She explained further that only the hospice care staff administered the cream, but that she cleaned and washed the area.

On 4/4/22, I received by email and reviewed requested documents provided by licensee Jim Maxson. These included hospice care notes for Resident A. The notes received generally described Resident A as being comfortable at the home. There was one noted instance where Resident A expressed concern about the area of skin. The notes indicate Resident A received the cream.

On 4/28/22, I interviewed licensee Jim Maxson at the facility. Mr. Maxson reported that his staff are trained to provide medications to residents. He described a three-day process of training on "Medcart" and displaying mastery before being allowed to pass medication to residents. He stated that narcotics are counted twice a day at shift change.

I reviewed the February 2022 medication administration record (MAR) for Resident A. There did not appear to be any discrepancies or omissions in the record. Scheduled and PRNs were administered. The document included the purpose of the PRN medication such as "For Pain" and staff initials were noted.

Voicemails to Hospice nurse Katherine Putnam were left but no return calls were received.

APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: (a) Medications.
ANALYSIS:	Interviews were conducted with staff and licensee. Documents were reviewed, including hospice care notes and MAR. Resident A received her topical cream medication once dry skin at the sacrum was identified.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Staff did not provide meals to Resident A.

INVESTIGATION:

The complainant stated the home did not provide meals while she visited with Resident A.

Ms. Caudill stated that the complainant would bring food into Resident A and therefore the home did not provide meals on those dates. Ms. Caudill stated food was always offered to Resident A. Ms. Caudill indicated that Resident A's relative would often decline food on her behalf, either claiming that Relative A could not eat the meal prepared, or that Resident A's relative provided meals. Ms. Caudill denied that there was a physician's order for a special diet.

Mr. Maxson stated staff offer meals, beverages, and snacks throughout the day. He indicated that he purchases food from a variety of stores, such as Sam's Club, Gordon Foods, Trader Joe's, Costco and Sysco. He reported that cook Terry Hayes prepares the meals and that staff distribute the meals to the residents. He reported that Resident A's weight was 197.7 pounds.

On both 3/30 and 4/28/22, I viewed the residents of the home. The residents looked well and on the 30th I witnessed the residents partaking in the lunch meal in the dining room.

APPLICABLE RULE	
R 400.15313	**Resident nutrition.**
	(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.
ANALYSIS:	Residents were observed eating lunch. Resident A did not have an order for a special meal. Meals appear to have been appropriately sourced by the home and there is no evidence that meals were not offered to Resident A.
CONCLUSION:	**VIOLATION NOT ESTABLISHED.**

ALLEGATION:

Narcotics were stolen.

INVESTIGATION:

The complainant stated that Employee #1 had informed her that five staff had been fired for stealing narcotic medications from residents.

Ms. Caudill denied the allegation that five staff had been terminated for stealing medications. She stated that only one staff was fired: Employee #1. Ms. Caudill stated that Employee #1 was let go because she was not a good fit for the home and caused discord among other staff and family members. Ms. Caudill denied missing medications and that any narcotics had been stolen. She elaborated that there is a system where narcotics are counted from shift to shift.

Mr. Maxon also denied any theft of medication had occurred at the home.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(6) A licensee shall take reasonable precautions to insure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.

ANALYSIS:	Mr. Maxson and Ms. Caudill reported that controlled medications are counted between shifts to reconcile the number of pills dispensed, with the overall number of pills provided. Ms. Caudill, identified as a person who gave Resident A her medications, has reportedly been trained to do so.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Staff did not respond to Resident A's call for assistance.

INVESTIGATION:

Ms. Caudill stated that the call devices in the rooms were all operable. She reported that if Resident A used the call button, staff would respond. She did give examples of instances where staff responded, asked questions of Resident A, received a positive response, then Relative A would call a short while thereafter to complain on Resident A's behalf.

On 4/28/22 I interviewed Mr. Maxson. He stated that his facility did not have an electronic tracking system to measure response times, but that staff are held to a two-minute standard of promptness.

APPLICABLE RULE	
R 400.15310	**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:	Mr. Maxson and Ms. Caudill denied that they told Resident A not to use her call device during certain times of the day such as shift change. There was no evidence to suggest that Resident A's calls for service were denied or delayed.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A's room was not cleaned.

INVESTIGATION:

On 3/30/22 I made an unannounced visit. I was able to inspect several rooms and they were clean and well maintained. The rooms appeared to be compliant with applicable licensing rules.

APPLICABLE RULE	
R 400.15403	**Maintenance of premises.**
	(2) Home furnishings and housekeeping standards shall present a comfortable, clean, and orderly appearance.
ANALYSIS:	Resident A was not present during home visits, as she had been moved to a different facility at the time the complaint was received. However, during the unannounced inspection, rooms were observed to be well maintained and clean.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 4/28/22, I completed an exit conference with licensee Mr. Jim Maxson face to face. Mr. Maxson agreed with the findings that no violations were established during the course of the investigation.

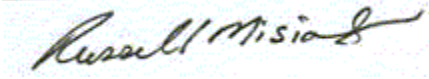
IV. RECOMMENDATION

I recommend the status of the license remain unchanged.

5/18/22

Dwight Forde Date
Licensing Consultant

Approved By:



6/21/22

Russell B. Misiak Date
Area Manager