GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 28, 2024

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

RE: License #: AH250236841
Investigation #: 2024A0784082
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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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) 284-9730.

Sincerely,

Aaron L Clum

Aaron Clum, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 230-2778

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH250236841
Investigation #:	2024A0784082
Complaint Receipt Date:	08/05/2024
Investigation Initiation Date:	08/05/2024
Report Due Date:	10/04/2024
Licensee Name:	Flint Michigan Retirement Housing LLC
Licensee Address:	14005 Outlook Street Overland Park, KS 66223
Licensee Telephone #:	(240) 595-6064
Administrator/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:	08/01/2024
Expiration Date:	07/31/2025
Capacity:	114
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
The facility did not adhere to Resident A's DNR order	Yes
Additional Findings	No

III. METHODOLOGY

08/05/2024	Special Investigation Intake 2024A0784082
08/05/2024	Special Investigation Initiated - Telephone Interview with Associate 1
08/05/2024	Contact - Document Sent Special Investigation documentation/information request sent via email
08/05/2024	Exit Conference conducted with Associate 1

ALLEGATION:

The facility did not adhere to Resident A's DNR order

INVESTIGATION:

On 8/05/2024, the department received this online complaint. Due to the anonymous nature of the complaint, additional information could not be obtained.

According to the complaint, Resident A was a person on hospice with a do-not-resuscitate order (DNR). On approximately 7/30/2024, wellness director Lauire Wolf performed CPR on Resident A despite the DNR.

On 8/05/2024, I interviewed Associate 1 by telephone. Associate 1 stated she did initially perform CPR on Resident A as she was not immediately aware if Resident A was a DNR or not. Associate 1 stated Resident A, who passed away, lived in building two of the four buildings on the property. Associate 1 stated she had received a call that Resident A was non-responsive, so she went to building two from the building she was in at the time. Associate 1 stated that when she arrived, several staff were present, and she asked if Resident A had a DNR or not. Associate 1 stated none of the staff present knew Resident A was a DNR, so Associate 1

requested someone find out. Associate 1 stated each building has an emergency book with each resident's face sheet which indicates, with a red sticker, if that person is a DNR or not. Associate 1 stated she did not know why, but the staff member who went to check Resident A's status went to building one and brought back the book from that building. Associate 1 stated that staff were attempting to get ahold of hospice during this whole time also to see if they knew if Resident A was a DNR. Associate 1 stated that when the staff brought the emergency book to building two, Resident A's face sheet did not have a red sticker to identify her as a DNR. Associate 1 stated that it was not until approximately 15 minutes after she arrived at building two and staff started trying to contact hospice, that someone from hospice called back and informed her that Resident A was a DNR. Associate 1 stated she did perform CPR on Resident A until she received notification from hospice of the DNR status. Associate 1 stated she later found out that while Resident A's face sheet did not have the red sticker, there was a small, checked box on the face sheet indicating she was a DNR. Associate 1 stated she did not think to look for this box as it was not common practice, and it was not easy to identify on the face sheet. Associate 1 stated building two does have an emergency book and she did not know why staff did not review that book first.

I reviewed Resident A's *DO NOT RESUSITATE ORDER*, provided by director of operations Sera Henry.

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:	The complaint alleged that CPR was performed on Resident A while she was passing even though Resident A had a DNR order. The investigation revealed that CPR was initially performed on Resident A due to the facilities procedures for DNR notification not being in place. Based on the findings, the facility is not in compliance with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, it is recommended that the status of the license remain unchanged.

8/26/2024

_____

Aaron Clum — Date
Licensing Staff

Approved By:

08/27/2024

_____

Andrea Moore — Date
Area Manager