GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 30, 2024

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

RE: License #: AH250236841
Investigation #: 2024A0784086
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. If 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 #:	2024A0784086
Complaint Receipt Date:	08/15/2024
Investigation Initiation Date:	08/16/2024
Report Due Date:	10/14/2024
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:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Inadequate supervision of Resident A	Yes
Additional Findings	No

III. METHODOLOGY

08/15/2024	Special Investigation Intake 2024A0784086
08/16/2024	Special Investigation Initiated - On Site
08/16/2024	Inspection Completed On-site
08/30/2024	Exit - Email Report sent to authorized representative/administrator Eric Simcox

ALLEGATION:

Inadequate supervision of Resident A

INVESTIGATION:

On 8/15/2024, 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 had a fall from his bed on 8/10/2024 due to a lack of adequate supervision.

On 8/16/2024, I interviewed operations director Sera Henry and wellness director Laurie Wolf at the facility. Ms. Henry stated Resident A is a is bed bound and is a “total assist” requiring staff assistance with activities of daily living (ADLs) which includes at least two staff for transfers, staff assistance with incontinence care, assistance with feeding and regular repositioning. Ms. Henry stated Resident A is also receiving hospice services. Ms. Henry stated Resident A is unable to voice his needs. Ms. Henry stated Resident A receives safety checks from staff every two to three hours during waking hours and every three to four hours during sleep hours. Ms. Henry stated Resident A currently has a hospital bed which is kept in the lowest position and a fall mat next to his bed. Ms. Henry stated foam wedges are also used to help with Resident A’s repositioning. Ms. Henry stated that it was not common

behavior for Resident A to move in bed in a way which would cause him to roll out. Ms. Henry stated Resident A was admitted to the facility on 2/26/2024. Ms. Wolf stated Resident A's recent fall was during third shift on 8/10/2024. Ms. Wolf stated Resident A was found by staff laying on his stomach after presumably rolling out of bed. Ms. Wolf stated that after the fall, she initially had Resident A's bed moved against the wall to limit the possibility of him falling out. Ms. Wolf stated the bed has since been moved back away from the wall as Relative A, Resident A's authorized representative, did not want him to have to lay facing the wall. Ms. Wolf stated that a bed alarm has also been ordered for Resident A. Ms. Wolf stated Resident A did have one previous time, on 7/10/2024, which he was observed having presumably fallen out of bed. Ms. Wolf stated that unlike the recent fall, he did not sustain any injuries at that time.

On 8/16/2024, I observed Resident A in his room. At the time of the onsite, Resident A was in a reclining chair in his room and was being assisted with a meal. Resident A's bed was raised up at the time. Ms. Wolf stated the bed is raised when staff need to provide assistance or transfer him out of bed. There was also a mat by the bed and the bed was pulled away from the wall.

I reviewed an Accident/Injury Report for Resident A, provided by Ms. Henry. The report was dated 8/10/2024 and read consistently with Ms. Wolfes statements. The report indicated the incident time was 2:30am.

I reviewed facility *Charting Notes* for Resident A, provided by Ms. Henry. Notes dated 7/10/2024 read, "Resident was found on the floor this morning along side his bed. Resident is bed bound. Resident was assessed by staff, no injury noted. Denies pain. Hospice RN notified and came out to assess. Hospital bed and fall mat in place. Hospice nurse stated resident doesn't have a history of falls or rolling out of bed". Notes dated 8/10/2024 read "IR received for [Resident A] staff had found him on the floor on stomach had a rug burn on his left cheek bone and red knees and hand. Hospice was notified. I [Ms. Wolfe] assessed him at 9am and notified [Relative A1] of the incident. His bed has been moved against the wall and I called hospice to get a bed alarm a floor mat and reminded staff to make sure his wedges are pushed up under him on his left side".

I reviewed Resident A's service plan. Under a section titled *Fall Risk*, the plan read, "Bed in lowest position while not providing care, wedges in use at all times while in bed and chair". The service plan did not include any dates relative to the initial review completed or any updates related to changes in Resident A's needs.

I reviewed Resident A's *ADL log* for August 2024. Under a section titled INCONTINENT: INCONTINENT OF BOWEL & BLADDER, the log read "Check & change every 2 to 3 hours during waking hours and 3 to 4 hours during hours of sleep, and as needed".

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.**
R 325.1922	**Admission and retention of residents.**
	(5) A home shall update each resident's service plan at least annually or if there is a significant change in the resident's care needs. Changes shall be communicated to the resident and his or her authorized representative, if any.
ANALYSIS:	Review of the 7/10/204 charting notes, Resident A's service plan and ADL logs, along with statements provided by Ms. Henry and Ms. Wolfe, indicate that since the fall on 7/10/2024, addition of a bed alarm and repositioning foam are the two measures that have been pursued as corrective measure for Resident A's safety. It is notable that there is no indication, documented or otherwise, that after Resident A's fall on 7/10/2024 or after the most recent fall on 8/10/2024, additional fall prevention options were not considered or included, for example, an increase in the frequency of safety checks for Resident A, especially during the nighttime hours. Additionally, while Resident A's ADL log includes measures for checking on Resident A at least regularly throughout each shift, this information, review of the service plan revealed this information, along with the addition of the bed alarm as a safety measure, was not in the plan. Based on the findings, the facility is not in compliance with these rules.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

8/28/2024

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Aaron Clum — Date
Licensing Staff

Approved By:

08/30/2024

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