GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

November 18, 2024

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

RE: License #: AH250236841
Investigation #: 2025A0784006
Landings of Genesee Valley

Dear Mr. 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 #:	2025A0784006
Complaint Receipt Date:	10/14/2024
Investigation Initiation Date:	10/15/2024
Report Due Date:	12/13/2024
Licensee Name:	Flint Michigan Retirement Housing LLC
Licensee Address:	14005 Outlook Street Overland Park, KS 66223
Licensee Telephone #:	(240) 595-6064
Administrator:	Zachary Fisher
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 protection of Resident A	Yes
Additional Findings	No

III. METHODOLOGY

10/14/2024	Special Investigation Intake 2025A0784006
10/15/2024	Special Investigation Initiated - On Site
10/15/2024	Inspection Completed On-site
10/15/2024	Exit Conference Conducted with operations manager Sera Henry

ALLEGATION:

Inadequate protection of Resident A

INVESTIGATION:

On 10/14/2024, 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 in her room. Resident A was heard hitting the wall. Staff working at the time had gone on break. No staff names, dates or times were provided in relation to this complaint.

On 10/15/2024, I interviewed operations manager Sera Henry (OM) at the facility. Employee 1 was present by speaker phone. Ms. Henry stated that on 9/15/2024, employee 1 and employee 2 were working in Resident A's building, building 4. OM stated that at approximately 8pm that evening, employee 1 was relieved for a break. OM stated employee 1 left the building for her break. OM stated shortly after employee 1 left for break, employee 2 could hear Resident A hitting her wall and yelling in her room. OM stated employee 2 went to Resident A's room, but was unable to enter as the door was locked from the outside. OM stated employee 2 did not have a key to unlock the door as employee 1 had taken it the key with her on break. OM stated employee 1 sent a text to employee 2 regarding the situation and that within a few minutes of having left, employee 1 returned to the building to unlock

the door. OM stated that by the time employee 1 returned, Relative A was at the building and waiting at the door. OM stated employee 1 unlocked the door and that Relative A went into the room ahead of employee 1 and 2. OM stated Relative A would not allow employees 1 and 2 to assist Resident A. OM stated that EMS had been called and that when they arrived Relative A refused to allow EMS to take her to the hospital as Resident A appeared to be ok. OM stated both employee 1 and 2 have provided written statements. OM stated that the key to access resident rooms should always be in the facility. OM stated it was not acceptable to have the key taken from the facility.

I reviewed statements from employees 1 and 2, provided by OM. The statements read consistently with statements provided by OM.

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.**
For Reference: R 325.1901	**Definitions:**
	(p) "Protection" means the continual responsibility of the home to take reasonable action to ensure the health, safety, and well-being of a resident as indicated in the resident's service plan, including protection from physical harm, humiliation, intimidation, and social, moral, financial, and personal exploitation while on the premises, while under the supervision of the home or an agent or employee of the home, or when the resident's service plan states that the resident needs continuous supervision.

ANALYSIS:	The complaint alleged a lack of adequate protection for Resident A after she fell, and staff had gone on break. The investigation revealed that while employee 2 was present when Resident A fell, the key to access Resident A's room was not available as employee 2 had left for break with the key. The operations manager acknowledged that a key to access resident rooms should always been available to staff and should not have been taken from the building. 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.

Aaron L Clum 11/18/2024

Aaron Clum Date
Licensing Staff

Approved By:

Andrea L Moore 11/21/2024

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