GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 10, 2022

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

RE: License #: AH250236841
Investigation #: 2022A0784022
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.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party 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. 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 #:	2022A0784022
Complaint Receipt Date:	01/06/2022
Investigation Initiation Date:	01/06/2022
Report Due Date:	03/07/2022
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:	03/07/2021
Expiration Date:	03/06/2022
Capacity:	114
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A was transferred improperly	Yes
Resident A did not receive his medications	No
Additional Findings	No

III. METHODOLOGY

01/06/2022	Special Investigation Intake 2022A0784022
01/06/2022	Special Investigation Initiated - Telephone Interview with complainant
01/12/2022	Inspection Completed On-site
01/12/2022	Inspection Completed-BCAL Sub. Compliance
01/12/2022	Exit Conference Conducted with administrator Pauline Bednarick

ALLEGATION:

Resident A was transferred improperly

INVESTIGATION:

On 1/06/2022, the department received this online complaint.

According to the complaint, Staff A attempted to transfer Resident A from his wheelchair to his bed by herself with a Hoyer lift at which time the Hoyer tipped causing Resident A to fall to the floor. Resident A requires two staff for transfers with the Hoyer.

On 1/06/2022, I interviewed complainant by telephone. Complainant stated Resident A lived at the facility from 10/22/2021 until 10/29/2021. Complainant stated Resident A is currently in a safe living environment. Complainant stated that on 10/26/2021, Staff A attempted to transfer Resident A by herself with a Hoyer lift. Complainant stated the Hoyer tipped during the attempted hitting Resident A while Resident A also fell to the floor at which time Resident A sustained a bump on the back of his head and reported arm and leg pain.

Review of the facility licensing file revealed the facility submitted a report regarding the Complainants noted incident on 10/24/2021. Under a section titled *Explain What Happened/Describe Injury*, the report read "on 10/24/2021 during transfer the Hoyer lift malfunctioned and landed on the resident. No visual injuries noted. Resident complained of Right top forearm hurting staff assessed no injuries noted. Today 10/28/2021 resident states that he feels dizzy and having pain in the back of his head". Under a section titled *Action Taken by Staff/Treatment Given*, the report read "10/24/2021 Nurse did a complete body assessment no injury or bruising noted No pain with ROM. Resident stated no pain in his arm. Resident has slight pain on palpating to back of head no redness or bruising noted. 10/28 checked vitals, put in bed, PCP notified sent to ER for evaluation and treatment". Under a section titled Corrective Measures Taken to Remedy and/or Prevent Recurrence, the report read "Monitor resident for signs or symptoms of dizziness and or pain and notify PCP Immediately to evaluate and treat. Will check residents Blood pressure daily and orders to hold blood pressure meds if blood pressure reads below parameters. DME called and new Hoyer and hospital bed ordered and delivered".

On 1/12/2022, I interviewed administrator Pauline Bednarick at the facility. Ms. Bednarick stated that on 10/24/2021, Staff A did attempt to transfer Resident A by herself with the required Hoyer lift. Ms. Bednarick stated that according to reporting, Resident A strongly insisted he wanted to be transferred and did not care if a second staff person was not present to help. Ms. Bednarick stated Staff A then attempted to transfer Resident A on her own at which time the Hoyer reportedly became stuck on the bed causing it to lean forward onto the bed. Ms. Bednarick stated Staff A then lowered Resident A to the floor. Ms. Bednarick stated Staff A should not have attempted to transfer Resident A without a second staff as noted in Resident A's service plan.

I reviewed a written statement, provided by Ms. Bednarick, signed by Staff A and dated 10/28/21, which read consistently with statements provided by Ms. Bednarick regarding the details of the attempted self-Hoyer transfer.

I reviewed Resident A's service plan which was consistent with
Ms. Bednaricks statements regarding Resident A's transfer requirements.
Specifically, the plan indicates Resident A requires a "2-person physical assist" with a "Hoyer".

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.
For Reference: R 325.1901	**Definitions**
	(16) "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 Resident A was transferred improperly. The investigation revealed associate Staff A failed to adequately transfer Resident A on 10/24/2022, by herself, while knowing the transfer required two staff. Based on the findings the allegation is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A did not receive his medications

INVESTIGATION:

When interviewed, Complainant stated that on 10/28/2021, staff did not administer Resident A his blood pressure or Atrial fibrillation [afib, a disease of the heart characterized by irregular and often faster heartbeat]. Complainant stated the medication technician (med tech) on duty stated Resident A had orders from his physician not to administer the blood pressure medication if his blood pressure was below 110. Complainant stated she is not aware of any such directive from Resident A's physician.

When interviewed, Ms. Bednarick stated she was not aware of any issues related to Resident A's medications not being administered correctly.

I reviewed *Physicians Orders* for Resident A, provided by Ms. Bednarick. The orders indicated Resident A was prescribed *ELIQUIS TAB 5MG* and was supposed to take "1 tablet by mouth twice daily related to afib" and *CARVEDILOL TAB* 6.25MG and was supposed to take "1 tablet by mouth twice daily related to hypertension [high blood pressure] **hold for systolic blood pressure less than 110 and pulse below 60".

I reviewed Resident A's medication administration record (MAR), provided by Ms. Bednarick. The MAR indicated Resident A was not administered the morning dose of his *CARVEDILOL* on 10/28/2021. Accompanying *Admin History* notes related to the MAR, also provided by Ms. Bednarick, indicated this dose was "withheld for vitals" further indicating his vitals were 91/53 at that time. Additionally, the MAR indicated Resident A was administered his *ELIQUIS* as prescribed on 10/28/2021.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(1) Medication shall be given, taken, or applied pursuant to labeling instructions or orders by the prescribing licensed health care professional.

ANALYSIS:	The complaint alleged Resident A did not received his CARVEDILOL and ELIQUIS medications, as prescribed, on 10/28/2021. Review of Resident A's MAR revealed he did receive his ELIQUIS medication as prescribed. While the MAR indicated he missed a dose of his CARVEDILOL, review of staff charting notes revealed the medication was withheld appropriately as directed within the orders from Resident A's physician. Based on the findings, the allegation is not substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

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

2/01/2022

Aaron Clum Date
Licensing Staff

Approved By:

02/09/2022

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