GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 28, 2023

Joellen Deilus
3721 Indian Trail
China, MI 48054

RE: License #: AM740389877
Investigation #: 2023A0580018
Visions AFC

Dear Ms. Deilus:

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. Failure to submit an acceptable corrective action plan will result in disciplinary action.

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) 643-7960.

Sincerely,

Sabrina McGowan, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 835-1019

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AM740389877
Investigation #:	2023A0580018
Complaint Receipt Date:	01/20/2023
Investigation Initiation Date:	01/20/2023
Report Due Date:	03/21/2023
Licensee Name:	Joellen Deilus
Licensee Address:	3721 Indian Trail China, MI 48054
Licensee Telephone #:	(586) 381-4218
Administrator:	Joellen Deilus
Licensee Designee:	N/A
Name of Facility:	Visions AFC
Facility Address:	868 N Carney Dr St Clair, MI 48079
Facility Telephone #:	(810) 326-1688
Original Issuance Date:	02/28/2018
License Status:	REGULAR
Effective Date:	08/31/2022
Expiration Date:	08/30/2024
Capacity:	12
Program Type:	PHYSICALLY HANDICAPPED MENTALLY ILL ALZHEIMERS

	AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A arrived at the ED (Emergency Department) with a UTI (Urinary Tract Infection). Resident A has symmetrical bruising around her neck, as if she is wearing a necklace. Resident unable to communicate. POA, did not receive any calls regarding injury.	No
Complainant states Resident B has been given potassium every day even though she's only supposed to receive it every other day.	Yes

III. METHODOLOGY

01/20/2023	Special Investigation Intake 2023A0580018
01/20/2023	APS Referral This complaint was opened by APS for investigation.
01/20/2023	Special Investigation Initiated - Telephone A call was made to Mr. Steven Dutcher, APS, St. Clair Co.
01/20/2023	Contact - Document Received An emailed incident report regarding Resident A was received.
01/20/2023	Contact - Telephone call made A call was made to Relative Guardian A.
01/23/2023	Inspection Completed On-site An onsite inspection was conducted. Contact was made with Ms. Jennifer Yielding, Mgr.
01/25/2023	Inspection Completed On-site A virtual interview was conducted with Resident A
02/06/2023	Contact - Telephone call made Spoke with Ms. Kim Bica, Flagstar Home Health Nurse.
02/16/2023	Inspection Completed On-site A follow-up onsite inspection was conducted.

02/16/2023	Contact - Document Received Email from Mr. Steven Dutcher of APS.
02/22/2023	Contact - Telephone call made Call to officer Jared McClure of the Port Huron Sheriff's department.
02/27/2023	Contact - Telephone call made Follow-up call was made to Relative Guardian A.
02/27/2023	Contact - Telephone call made Call was made to Relative Guardian B.
02/27/2023	Exit Conference An exit conference was held with the licensee designee, Ms. Deilus.

ALLEGATION:

Resident A arrived at the ED Emergency Department with a UTI. Resident A has symmetrical bruising around her neck, as if she is wearing a necklace. Resident unable to communicate. POA, did not receive any calls regarding injury.

INVESTIGATION:

On 01/20/2023, I received a complaint via BCAL Online Complaints. This complaint was opened by APS for investigation.

On 01/20/2023, I spoke with Mr. Steve Dutcher of Adult Protective Services (APS), in St. Clair County. He shared that medical staff stated that the bruising observed on Resident A is more so near her clavicle than her neck. He intends on visiting with Resident A at the hospital today to obtain photos.

On 01/20/2023, I received an emailed copy of the incident report dated 01/19/2023 for Resident A. It states that staff called with concerns, change in mental status, difficulty staying awake. The licensee was notified. Resident A's Power of Attorney (POA) and the Emergency Medical Services (EMS) were called. Resident A was shipped to McLaren Hospital for evaluation and treatment. Resident A was admitted on 01/20/2023.

On 01/20/2023, I spoke with Relative Guardian A. She stated that Resident A was previously released from the hospital on 01/15/2023. During that time, she was rough handled by 2 nurses that put her in the car. She does not believe that the bruises were caused by the staff at Visions AFC. She believes that they were caused by hospital

staff and will make the appropriate complaint. She has contacted law enforcement as well. She states that Resident A was hospitalized on 12/29/2022-01/01/2023, 01/10/2023-01/15/2023 and again on today, 01/20/2023 due to recurring UTI's and dehydration. Resident A is non-verbal and unable to drink or eat on her own. She also wears briefs and depends on the staff to be changed and cleaned. She has concerns if staff are giving her enough water and wiping her appropriately.

A copy of photos depicting Resident A's bruises were received. Circular bruising, purple in color, was observed in the same place on both Resident A's left and right clavicle/neck area.

On 01/23/2023, I conducted an onsite inspection at Visions AFC, along with assigned APS worker, Mr. Dutcher. Contact was made with the manager, Ms. Jennifer Yielding. Ms. Yielding informed me that a resident tested positive for Covid 19 this morning. Ms. Yielding denied the allegations that the facility caused the bruising seen on Resident A. Resident A is elderly and has frail skin. She stated that Resident A was hospitalized from 01/10/2023-01/15/2023. She returned to the home later that evening having been transported by Relative Guardian A's spouse. Once she got Resident A inside and looked her over, she observed some bruising and completed a skin anatomy diagram noting the areas on her skin. Resident A was sent back out to the hospital on 01/19/2023 and has not returned. She adds that she has been contacted by Officer Jared McClure of the Port Huron Sheriff's department. He has requested a copy of the skin anatomy diagram completed.

She adds that Resident A is prone to bladder infections as she loses the urge to eat or drink. Resident A is diagnosed with dementia. She is incontinent and losing her ability to stand on her own. Resident A requires assistance with mobility. The family has declined hospice care. She believes that Resident A requires nursing care. She will be issuing a 30-day notice due to the home no longer being able to meet the needs of the resident.

A copy of the skin diagram completed by Ms. Yielding on the date of Resident A's return to the home on 01/15/2023 was obtained. The graph depicts bruising observed on Resident A's shoulder/clavicle area, and circle like bruising (appearing as fingerprints) on both her left and right shoulders, neck, and clavicle area.

The Incident Report (IR) dated 01/10/2023 states that Resident A had a change in mental status. Couldn't answer staff and had trouble staying awake. Staff contacted the Power of Attorney. Family transported Resident A via personal vehicle to McLaren Port Huron for treatment/evaluation. Resident A was admitted on 01/10/2023.

The McLaren Port Huron discharge summary for Resident A, dated 01/15/2023, states that Resident A was seen and treated for an Altered Mental Status and a Urinary Tract infection. She was prescribed Amoxicillin 125mg, 1 oral every 12 hours, for 10 days and Thiamine, 100mg, oral daily, for 90 days. Any follow-up care will be with her primary physician.

On 1/23/2023, while onsite at this home an observation of the other residents in the home was made. The residents were observed in the dining room area eating lunch. Staff was also present assisting some of the residents with eating their food. The residents responded that they are doing well when asked. They were adequately dressed and seemed to be receiving appropriate care.

On 02/02/06/2022, I spoke with Ms. Kim Bica, Flagstar Home Health Nurse assigned to Resident A. She stated that she has worked with Resident A since she was in her own home placement prior to entering the AFC. She stated that she typically visits with her at the AFC home at least twice per week. She shared that she first visited Resident A on Wednesday 1/18/2023, 3 days after she'd been released from the hospital back to the AFC. When she has Resident A sit on the bed to do an assessment, she saw the bruising. The bruising, located on her sternum and fingerprint bruises on her arms, was deep purple, which typically happens within the first 5 days. She immediately asked the manager, Ms. Yielding how the bruising occurred. Ms. Yielding then responded that she came home from the hospital with bruising, which she had documented. In an attempt to figure out how the bruising might have occurred, giving her best guess, it appears to be as a result of someone attempting to reposition her from behind. She has spoked to Relative Guardian A who shared that the hospital staff handled Resident A rough.

Ms. Bica states that she expressed concern with the manager regarding Resident A's recurring UTI's. Otherwise, staff at the home have always appeared kind and compassionate about meeting the needs of the residents in the home. She had no immediate concerns.

On 02/16/2023, I conducted an onsite inspection at Visions AFC. Home Manager, Ms. Ms. Yielding, confirmed that Resident A did not return to the facility. Other residents, along with 3 staff, were observed in the kitchen and dining area as residents were gathering to eat lunch. Another resident was observed watching TV in the living room area while one resident remained in her room. The residents were observed as receiving adequate care.

On 02/16/2023, I received an email from Mr. Steven Dutcher of APS indicating that he has closed the APS with no findings of abuse and/or neglect.

On 02/22/2023, I placed a call to officer Jared McClure of the Port Huron Sheriff's department. A voice mail message was left requesting a return call.

On 02/27/2023, I made a follow-up call was made to Relative Guardian A. She confirmed that Resident A did not return to the facility after her 01/20/2023 hospitalization. She is currently receiving skilled nursing care. She maintains that she never insinuated that bruises were caused by Visions AFC staff. The police have not done anything or charged anyone. She requested that Officer McClure review the hospital security footage on the day of Resident A's discharge. Although Resident A did

not return, she expressed overall concern with the number of UTI's Resident A had while at the facility.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Home manager, Ms. Jennifer Yielding denied the allegations She Resident A returned from the hospital 01/15/2023, transported by Relative Guardian A's spouse. Once inside, she observed some bruising and completed a skin anatomy diagram noting the areas on her skin. A copy of the skin diagram completed by Ms. Yielding on the on 01/15/2023, depicts bruising observed on Resident A's shoulder/clavicle area, and circle like bruising (appearing as fingerprints) on both her left and right shoulders, neck, and clavicle area. A copy of photos depicted circular bruising, purple in color, was observed in the same place on both Resident A's left and right clavicle/neck area. Mr. Steven Dutcher of APS indicating that he has closed the APS with no findings of abuse and/or neglect. Relative Guardian A stated that she does not believe that the bruises were caused by the staff at Visions AFC. Ms. Kim Bica, Flagstar Home Health Nurse assigned to Resident A, stated staff at the home have always appeared kind and compassionate about meeting the needs of the residents in the home. Based on the interviews conducted and the documents reviewed, there is not enough evidence to support the rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Complainant states Resident B has been given potassium every day even though she's only supposed to receive it every other day.

INVESTIGATION:

On 01/23/2023, I received an additional complaint stating that Resident B has been given potassium every day even though she's only supposed to receive it every other day.

On 01/25/2023, I spoke to Ms. Jennifer Yielding, home manager. She stated Resident B was hospitalized on 10/31/2022. At that time Resident B was prescribed to take her medication daily. Resident B was released on 11/02/2022. Her discharge paperwork did not indicate that there was any change in her medication, so staff continued to give it as prescribed. However, on 11/29/2023 her prescription came in stating that the medication is to be taken once every other day. She was never notified of a prescription change. Resident A's daily dosage was discontinued immediately.

On 01/25/2023, I conducted a virtual interview and observation of Resident B. Resident B stated that she has been receiving her medication as prescribed to her knowledge.

The IR dated 10/31/2023 states that Resident A stated that she was short of breath. Staff actions included contacting Resident 'Bs POA (Power of Attorney), called EMS and sent resident to Lake Huron Medical Center.

The 11/02/2022 Lake Huron Medical Center discharge summary for Resident B states that Resident B shall be given Spironolactone, 25mg, 1 tab, daily for 30 days.

The MARS for November 2022 states that the medication was given Spironolact, 25mg, 1 tab, daily, except for 11/01, 11/02, and 11/03/2022, while out of the facility.

The 11/29/2022 bubble pack medication delivered to the AFC for Resident A, dated 11/29/2022, states that Resident B shall be given Spironolact, 25mg, 1 tab, every other day.

The MARS for December 2022 states that the medication was given Spironolact, 25mg, 1 tab, daily, except for 12/4, 12/5, 12/6 and 12/09/2022, while out of the facility.

The MARS for Jan 2023 indicates that the Spironolact, 25mg, 1 tab was given daily during the month of January until 01/21/2023. Resident B began taking her medication, Spironolact, 25mg, 1 tab, every other day, effective 01/23/2023.

On 02/27/2023, I made a call to Relative Guardian B. She stated that she was made aware of the medication error that had been occurring. She stated that physician did

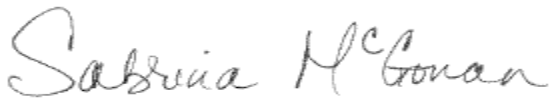
not make her aware of the medication change either. She has no concerns with the care that Resident B receives in the home.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Complaint received stating that Resident B has been given potassium every day even though she's only supposed to receive it every other day. Manager, Ms. Jennifer Yielding stated she was never verbally notified of prescription change, nor did she receive a physician's order. Resident A's 11/29/2022 prescription arrived, stating that the medication is to be taken once every other day, Resident B stated that she has been receiving her medication as prescribed to her knowledge. The 11/29/2022 bubble pack medication delivered to the AFC for Resident A, dated 11/29/2022, states that Resident B shall be given Spironolact, 25mg, 1 tab, every other day. The MARS for December 2022 states that the medication was given daily, except for 12/4, 12/5, 12/6 and 12/09/2022, while out of the facility. The MARS for Jan 2023 indicates that medication was given daily during the month of January until 01/21/2023. Based on the interview conducted and the documentation reviewed, there is substantial evidence to support the rule violation, that Resident B's medication was not being given as prescribed.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 02/27/2023, I conducted an exit conference with the licensee designee, Ms. Joellen Deilus. Ms. Deilus was informed of the findings of this investigation. A corrective plan was requested.

IV. RECOMMENDATION

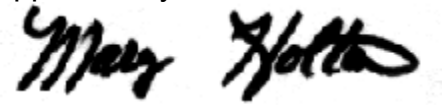
Upon the receipt of an approved corrective action plan, no changes to the status of the license is recommended.



February 28, 2023

Sabrina McGowan — Date
Licensing Consultant

Approved By:



February 28, 2023

Mary E. Holton — Date
Area Manager