GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 19, 2023

Joellen Deilus
3721 Indian Trail
China, MI 48054

RE: License #: AM740389877
Investigation #: 2023A0580040
Visions AFC

Dear Joellen 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 #:	2023A0580040
Complaint Receipt Date:	05/25/2023
Investigation Initiation Date:	05/25/2023
Report Due Date:	07/24/2023
Licensee Name:	Joellen Deilus
Licensee Address:	3721 Indian Trail China, MI 48054
Licensee Telephone #:	(586) 381-4218
Administrator:	Jennifer Yielding
Licensee Designee:	Joellen Deilus
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 AGED

	TRAUMATICALLY BRAIN INJURED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
During Resident A's stay, she had sustained 4 UTIs (Urinary Tract Infections). It was observed that Resident A's hair was greasy and Resident A smelled of body odor.	No
Home did not contact 911 after Resident A experienced chest pains.	Yes
Additional Findings	Yes

III. METHODOLOGY

05/25/2023	Special Investigation Intake 2023A0580040
05/25/2023	APS Referral
05/25/2023	Special Investigation Initiated - Letter A referral was made to APS.
06/15/2023	Inspection Completed On-site Contact with the manager, Jennifer Yielding.
07/11/2023	Contact - Telephone call made Call to staff, Lisa Lutz.
07/11/2023	Contact - Telephone call made Call made to the complainant.
07/12/2023	Contact - Telephone call made Call made to Relative Guardian A.
07/14/2023	Contact - Telephone call made Spoke with Relative Guardian A.
07/19/2023	Exit Conference An exit conference was held with the licensee, Joellen Delius.

ALLEGATION:

During Resident A's stay, she had sustained 4 UTIs. It was observed that Resident A's hair was greasy and Resident A smelled of body odor.

INVESTIGATION:

On 05/25/2023, I received a complaint via BCAL Online complaints.

On 05/25/2023, I made a referral to APS, sharing the allegations alleged in this complaint.

On 06/15/2023, I conducted an onsite inspection at Visons AFC. Contact was made with the manager, Jennifer Yielding. She denied the allegations that Resident A was not receiving proper care. She stated that oftentimes Resident A would refuse her shower. She stated that she spoke with the family regarding Resident A resisting showers, informing them that they cannot force her to do so.

On 06/15/2023, while onsite, staff members Charlotte Leverenz, Maureen Malory and Debra Gibson were present. There are currently 8 residents in the home. Residents were observed eating lunch in the dining area, while 1 resident was observed in her room. Resident were observed being jovial as they engaged in conversation at the dining table. They were dressed appropriately and appeared to be receiving appropriate care.

On 06/15/2023, Resident B, observed while in her room, stated that she is fine and did not feel like eating at that time. She was adequately dressed, appeared to be receiving proper care and expressed no concerns with the care she receives in the home.

The AFC assessment plan for Resident A states that staff are to assist with bathing, grooming and personal hygiene.

On 07/11/2023, complainant stated that Resident A obtained 4 UTI's while residing at the facility, while only having 2 prior to living with family. In addition, they did not brush her dentures or wash her hair regularly. Resident A was also found having had dried stool on her bottom at least once during her stay.

On 07/12/2023, I placed a call to Relative Guardian A. A voice mail message was left requesting a return call.

On 07/14/2023, I spoke with Relative Guardian A. Relative Guardian A stated noted her overall hygiene while residing at the facility was horrible. She stated that overall, she does not believe that Visions AFC is not a good facility due to mismanagement. She stated that staff are not educated on Dementia care. Resident A had lots of problems

while there, however, she is thriving in her new placement. Resident A has had only 1 UTI within the 3-month period at her new placement.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	It was alleged during Resident A' stay; she had sustained 4 UTI's and was observed that resident hair was greasy, smelled of body odor. Manager, Jennifer Yielding denied the allegations. The AFC assessment plan for Resident A states that staff are to assist with bathing, grooming and personal hygiene. Residents observed in the home were dressed appropriately and appeared to be receiving appropriate care. Resident B expressed no concerns with the care she receives in the home. The complainant stated that Resident A obtained 4 UTI's while residing at the facility, they did not brush her dentures or wash her hair regularly and was found having had dried stool on her bottom at least once during her stay. Relative Guardian A stated that Visions AFC is not a good facility due to mismanagement. Resident A had lots of problems while there, however, she is thriving in her new placement. Based on a review of the AFC assessment plan, interviews conducted with the complainant, Relative Guardian A, Home Manager, Jennifer Yielding, an interview with Resident B and an observation of the other residents in the home, there is not enough evidence to support the rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Home did not contact 911 after Resident A experienced chest pains.

INVESTIGATION:

On 06/15/2023, while onsite, Jennifer Yielding stated that to her knowledge, Resident A complained of chest pain and was given her PRN medication Nitroglycerin 0.4mg, before contacting Resident A's guardian (POA), who was given the option of transporting to the hospital. The guardian opted to transport Resident A to the hospital. No incident report was completed.

The April 2023 medication log for Resident A was obtained while onsite. It indicates that Resident A is prescribed Nitroglycerin 0.4 MG tablets, with 1 tablet to be taken sublingually (under the tongue) every 5 minutes as needed for chest pain, x3 doses, if no relief, call MD. The log indicates that Resident A was given 2 doses by staff identified as Lisa Lutz on 04/06/2023.

On 07/11/2023, I spoke with staff, Lisa Lutz. She could not recall the day in which Resident A was administered Nitroglycerin due to chest pain.

On 07/11/2023, I spoke with the complainant, who alleges that once Resident A who has a history of heart issues, complained of chest pain, staff on duty contacted the home manager who instructed staff to give Resident A a Nitroglycerin pill. After having given her a total of 3, manager Jennifer Yielding contacted Resident A's Guardian, who instructed the facility to call 911. The complainant states that the home makes them come transport when Resident A had to go to the hospital as opposed to calling 911.

On 07/12/2023, I spoke with Relative Guardian A who stated that around 5:45 am on the day in question, as she was preparing to leave for work, she received a call from the facility manager, Ms. Jennifer Yielding, stating that Resident A had complained of chest pains, was given 3 Nitroglycerin pills, which were not working. Ms. Yielding requested that she come and transport Resident A to the hospital. Upon calling her sister and informing her what was happening, her sister advised her to call the facility back and request that they contact 911, which she did. She then met Resident A at the hospital.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	It was alleged that the AFC home did not contact 911 after Resident A experienced chest pains. Manager, Jennifer Yielding stated that to her knowledge, Resident A complained of chest pain and was given her PRN medication Nitroglycerin 0.4mg, before contacting Resident A's Power of Attorney (POA), who was given the option of transporting to the hospital.

	The April 2023 medication log for Resident A was obtained while onsite. It indicates that Resident A is prescribed Nitroglycerin 0.4 MG tablets, with 1 tablet to be taken sublingually (under the tongue) every 5 minutes as needed for chest pain, x3 doses, if no relief, call MD. The log indicates that Resident A was given 2 doses by staff identified as Lisa Lutz on 04/06/2023. Staff, Lisa Lutz could not recall the day in which Resident A was administered Nitroglycerin due to chest pain. The complainant stated that once Resident A, complained of chest pain, staff on duty contacted the home manager who instructed staff to give Resident A a Nitroglycerin pill. After having given her a total of 3, manager Jennifer Yielding contacted Resident A's POA, who had to instruct the staff to call 911. Relative Guardian A stated that Ms. Yielding requested that she come and transport Resident A to the hospital. She advised her the facility to contact 911. Based on the interview conducted with the manager, Jennifer Yielding, the complainant, Relative Guardian A, and a review of the medication log for Resident A, there is enough evidence to support the rule violation due to staff not contacting the MD, but instead contacting Relative Guardian A, during a medical emergency.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 06/15/2023, I spoke with home manager, Jennifer Yielding. She stated that Resident A was scheduled for twice a week shower when she was residing in the AFC home, however, oftentimes she would refuse. Jennifer Yielding stated that she spoke with the family regarding Resident A resisting showers, informing them that they cannot force her to do so.

On 07/14/2023, I spoke with Relative Guardian A. Relative Guardian A stated that Resident A's overall hygiene while residing at the facility was horrible. She also believes

she went days without showers due to the facility allowing her to decline, even though she has dementia.

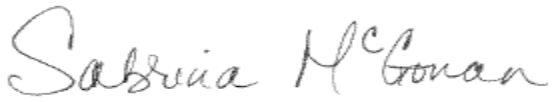
On 07/14/2023, I received a copy of the shower logs maintained for Resident A were received as follows: 02/14-Refused, 02/21, 03/14, 03/28, 04/05, 04/08-Refused, mean combative. No verification was provided for the weeks of 2/28/2023, 3/7/2023, 3/21/2023.

APPLICABLE RULE	
R 400.14314	**Resident hygiene**
	(1) A licensee shall afford a resident the opportunity, and instructions when necessary, for daily bathing and oral and personal hygiene. A licensee shall ensure that a resident bathes at least weekly and more often if necessary.
ANALYSIS:	Home manager, Jennifer Yielding stated that Resident A was scheduled for twice a week shower when she was residing in the AFC home, however, oftentimes she would refuse. Relative Guardian A stated that Resident A's overall hygiene while residing at the facility was horrible and she believes she went days without showers due to the facility allowing her to refuse. Shower logs maintained for Resident A do not reflect that Resident A was bathed weekly. Based on interviews conducted with home manager, Jennifer Yielding, Relative Guardian A, and documentation provided for Resident A, there is enough evidence to support the rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 07/19/2023, an exit conference was held with the licensee, Joellen Delius. She was informed of the findings of this investigation.

IV. RECOMMENDATION

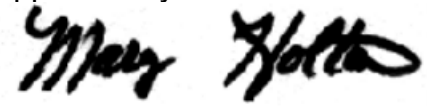
Upon the receipt of an approved corrective action plan, no change to the status of the license is recommended.



July 19, 2023

Sabrina McGowan — Date
Licensing Consultant

Approved By:



July 19, 2023

Mary E. Holton — Date
Area Manager