GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

November 13, 2023

Marva Townsend
Caring Meadows Living Center, Inc.
1001 Lafayette SE
Grand Rapids, MI 49507

RE: License #: AS410309723
Investigation #: 2024A0467002
Vi's Garden

Dear Mrs. Townsend:

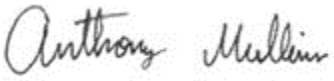
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even If you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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 (616) 356-0183.

Sincerely,



Anthony Mullins, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS410309723
Investigation #:	2024A0467002
Complaint Receipt Date:	10/06/2023
Investigation Initiation Date:	10/09/2023
Report Due Date:	12/05/2023
Licensee Name:	Caring Meadows Living Center, Inc.
Licensee Address:	1001 Lafayette SE Grand Rapids, MI 49507
Licensee Telephone #:	(616) 475-5433
Administrator:	Marva Townsend
Licensee Designee:	Marva Townsend
Name of Facility:	Vi's Garden
Facility Address:	1171 Lafayette S.E. Grand Rapids, MI 49507
Facility Telephone #:	(616) 635-2957
Original Issuance Date:	03/10/2011
License Status:	REGULAR
Effective Date:	12/25/2022
Expiration Date:	12/24/2024
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED, MENTALLY ILL, DEVELOPMENTALLY DISABLED, AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was sleeping on the floor with a box spring for more than two weeks.	Yes
Additional Findings	Yes

III. METHODOLOGY

10/06/2023	Special Investigation Intake 2024A0467002
10/06/2023	APS Referral Received from Kent County APS worker, Drew Blackall
10/09/2023	Special Investigation Initiated - Telephone
10/09/2023	Inspection Completed On-site
10/25/2023	Contact – telephone call made to Marva Townsend, Owner.
11/13/2023	Exit conference completed with the owner, Marva Townsend.

ALLEGATION: Resident A was sleeping on the floor with a box spring for more than two weeks.

INVESTIGATION: On 10/6/23, I received a BCAL online complaint from Kent County APS worker, Drew Blackall. The complaint stated that for nearly three weeks, staff at the AFC has been making Resident A sleep on the floor with a wood box spring. Three weeks ago, Resident A's bed was taken away. Resident A reportedly thought that management was replacing his bed, but they have yet to do so. Resident A reportedly asked the owner of the home, Marva Townsend about his bed and she told him that he is young enough to sleep on the floor. Whenever Resident A would ask about a new bed, he was given excuses as to why he does not have a mattress. Resident A reportedly has left upper extremity paralysis and is a fall risk. Therefore, it is dangerous for him to be sleeping on the floor. Resident A reportedly has a lot of back and joint pain.

On 10/9/23, I spoke to Drew Blackall with Kent County APS. He informed me that he spoke to Resident A this past Friday at his Day Program. Resident A disclosed to Mr. Blackall that he has been sleeping on a box spring and that the owner of the home informed him that she ordered a new mattress. Mr. Blackall stated that Resident A has been at the home for several years and likes living there. However, he just wants a mattress to sleep on.

On 10/9/23, I made an unannounced visit to United Methodist Community House in Grand Rapids, which is where Resident A attends day program. Introductions were made with staff member Jordan Garcia, and she assisted Resident A to the lobby to be interviewed. Resident A agreed to discuss case allegations. Resident A confirmed that he has resided at Vi's Garden for the past eight years. Resident A confirmed that he has been without a mattress for more than two weeks, resulting in him sleeping on a box spring on the floor. However, this past Friday (10/6/23), Resident A stated that he had a new mattress when he returned home from Day Program. Resident A stated, "all it took was a guy from the State of Michigan and it was there when I returned home." Resident A was referring to Kent County APS worker, Drew Blackall interviewing him this past Friday.

Resident A stated that his bed was taken away due to it being broken and having a bad box spring. Resident A stated that Mrs. Townsend was also redoing bedrooms and replacing carpet with linoleum flooring. Resident A stated that he was very uncomfortable sleeping on the floor. Resident A stated that whenever he would ask Mrs. Townsend about the status of his new bed, she would give him excuses to why she hasn't received the bed yet. Per Resident A, one of the excuses that Mrs. Townsend gave him was that her van broke down. Resident A could not recall the other excuses that Mrs. Townsend gave him. Resident A stated that Mrs. Townsend told him that he's small and the floor wouldn't hurt him. Resident A added that Mrs. Townsend insinuated that he's also young and could handle being on the floor. Resident A was adamant that this has been his only issue at the home. Outside of this incident, Resident A spoke highly of Mrs. Townsend and the staff at the home. Resident A was thanked for his time as this interview concluded.

On 10/9/23, I made an unannounced onsite investigation at the AFC home. Upon arrival, introductions were made with staff, and they allowed entry into the home. I made my way to the second floor of the home and observed Resident A's new mattress on his bed.

After verifying Resident A's sleeping arrangements, I interviewed staff member Dequita Merritt on the front porch of the facility. Ms. Merritt stated that she was unaware that Resident A did not have a mattress until Friday, October 6, 2023. Ms. Merritt stated that this past Friday, she noticed a new mattress lying in the hallway upstairs and Resident A informed her that it was his. Ms. Merritt asked Resident A where his old mattress was, and he stated he didn't have one. Ms. Merritt stated that she was shocked to know that Resident A didn't have a mattress for an unknown period of time, and she helped him put his mattress on his bed. Resident A thanked Ms. Merritt for assisting him.

On 10/25/23, I spoke to the owner of the home, Marva Townsend via phone. Mrs. Townsend stated that Resident A was without a mattress for three days as opposed to 2-3 weeks as alleged. While waiting to receive another mattress, Mrs. Townsend stated that Resident A was provided with 4 or 5 comforters on the box spring to make it comfortable. Mrs. Townsend stated that she is unsure as to what caused the

mattress to be delayed. However, when the mattress was finally delivered, it was delivered at her old facility directly down the street. Mrs. Townsend stated that Resident A was upset about the mattress situation because he wanted to stay in another room in the home. Mrs. Townsend stated that Resident A could not sleep in the other room because another resident was planning to move in that room.

On 11/13/23, I conducted an exit conference with Marva Towsend. She was informed of the investigative findings and aware a corrective action plan is due within 15 days of receipt of this report.

APPLICABLE RULE	
R 400.14410	**Bedroom furnishings.**
	(5) A licensee shall provide a resident with a bed that is not less than 36 inches wide and not less than 72 inches long. The foundation shall be clean, in good condition, and provide adequate support. The mattress shall be clean, comfortable, in good condition, well protected, and not less than 5 inches thick or 4 inches thick if made of synthetic materials. The use of a water bed is not prohibited by this rule.
ANALYSIS:	Resident A stated that he was without a mattress for more than two weeks. Mrs. Townsend stated that Resident A was without a mattress for three days. There is an obvious discrepancy in the amount of time Resident A was without a mattress. Regardless, at no point during his time at the facility should Resident A be without a mattress. Therefore, there is a preponderance of evidence to support the allegation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: While investigating the allegation listed above, Resident B informed me that she did not receive her medication on the morning of 10/9/23, despite asking for it. I spoke to AFC staff member, Ms. Merritt and she stated that her colleague Carolyn (last name unknown) told her that she provided Resident B with her medications today and she reportedly refused to take them and threw them across the kitchen. Except for this incident, Ms. Merritt denied any knowledge of Resident B or other residents not receiving their medications as scheduled.

Resident B's Medication Administration Record (MAR) was reviewed and did not have staff initials for the following medications on several dates between 10/1/23 and 10/9/23: Benzotropine Tab 1MG, Carboxymethy Sol 0.5%, Fluticasone SPR 50MCG,

Gabapentin Cap 400MG, Levothyroxin Tab 25MCG, Metamucil On-The-Go SF Packets, Montelukast Tab 10MG, Multivitamin Tab, Pantoprazole Tab 40MG, Symbicort AER 80-4.5.

Resident C's MAR was reviewed and did not have staff initials for the following medications on several dates between 10/1/23 - 10/9/23: Alendronate Tab 70MG, Aspirin Low CHW 81MG, Enalapril Tab 5MG, Famotidine Tab 20MG, Ferosul Tab 325MG, Fluoxetine Cap 10MG, Oyster Calcium+D, Pioglitazone Tab 30MG, Simvastatin Tab 40MG, Systane Ultr sol, Trazadone Tab 100MG, Vitamin D Cap 50000UNT, Vitamin E Cap 180MG, and Vraylar Cap 3MG.

Resident D's MAR was reviewed and did not have staff initials for the following medications on several dates between 10/1/23 – 10/9/23: Aspirin low dose 81MG, Atorvastatin Tab 40mg, Benztropine Tab 0.5MG, Calcium/vitamin D3 – Tab 600/200, Ferosul Tab 325MG, Fluphenaz De Inj 25MG/ML, Levothyroxin Tab 50MCG, Methylphenid Tab 10MG, Polyeth Glyc Pow 3350 NF, Sertraline Tab 100MG, True Metrix Tes Glucose, Trueplus Lancets 33GA, and Vitamin E 1000IU.

Resident E's MAR was reviewed and did not have staff initials for the following medications on several dates between 10/1/23 – 10/9/23: Amlodipine Tab 5MG, Atorvastatin Tab 20MG, Escitalopram Tab 5MG, Lisinopril Tab 20MG, Mag Ocide Tab 400MG, Melatonin Cap 10MG, Memantine Tab HCL 10MG, Qutiapine Tab 100MG, Symbicort AER 80-4.5, Tamsulosin Cap 0.4MG, Vitafus Prenat Asst Gummy, and Vitamin D2 50MCG.

Resident F's MAR was reviewed and did not have staff initials for the following medications on several dates between 10/1/23 – 10/9/23: Albuterol AER HFA, Atorvastatin Tab 10MG, Finasteride Tab 5MG, Lacosamide Tab 200MG, Linsinopril Tab 10MG, Prazosin HCL Cap 2MG, Propranolol Tab 10MG, Spiriva Cap HANDIHLR, and Tamsulosin Cap 0.4MG.

Resident A's MAR was also reviewed and did not have staff initials for the following medications on several dates between 10/2/23 – 10/9/23: Acetaminophen 325MG, Amphet/Dextr Tab 10MG, Aspirin low dose 81MG, Atorvastatin Tab 40MG, B-Complex Tab, Famotidine Tab 20MG, Fluoxetine Cap 20MG, Lisinopril Tab 10MG, Loratadine Tab 10MG, Multivatimin Tab, Risperidone Tab 3MG, Buspirone Tab 10MG, Buspirone Tab 5MG, Dexmethylphe Cap 10MG ER, and Diazepam Tab 2MG.

On 11/13/23, I conducted an exit conference with the owner, Marva Townsend. She was informed of the investigative findings and aware that a corrective action plan is due within 15 days of receipt of this report. I also informed Mrs. Townsend that this is a repeat violation from the renewal LSR dated 12/19/22. The corrective action plan that Mrs. Townsend submitted in response to the renewal LSR on 12/21/22 indicated that, *"compliance will be reached by double checking the MAR on a daily basis (staff cross checking each other) and looking at the possibility of using an*

electronic MAR system. Compliance is effective on 12/19/22. Marva Townsend is responsible for the correction and implementation." Based on the review off all six residents' MARs, it is clear that the Medication Administration Records are not being checked daily or cross checked by staff.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(a) Be trained in the proper handling and administration of medication.** **(b) Complete an individual medication log that contains all of the following information:** **(i) The medication.** **(ii) The dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.**
ANALYSIS:	Resident A, Resident B, Resident C, Resident D, Resident E, and Resident F consistently did not have their MAR's initialed between 10/1 and 10/9 for several medications, making it difficult to confirm if residents are receiving their medications as scheduled. Therefore, there is a preponderance of evidence to support the allegation.
CONCLUSION:	**VIOLATION ESTABLISHED** **(Repeat violation from 12/19/22 Renewal Licensing Study Report)**

INVESTIGATION: While investigating the allegations listed above, Resident B informed me that she and other residents are not eating fresh fruits and vegetables for meals. I spoke to Ms. Merritt and she stated that when she cooks for the residents, she tries to give them vegetables. Ms. Merritt stated that the home does not have any apples or oranges. Ms. Merritt stated that residents sometimes eat bananas with their cereal. Ms. Merritt stated that the home should have more fruits and vegetables available. While onsite, I observed one can of mixed fruit and several cans of vegetables. There were no fresh fruit or vegetables observed in the home.

On 10/25/23, I spoke to Mrs. Townsend about the lack of fruits and vegetables in the home. Mrs. Townsend stated that she provides fresh fruits and vegetables to the

home either weekly or bi-weekly. Mrs. Townsend stated that she tries to use these items first to prevent them from going bad and she knows that some residents don't care for fruits and vegetables.

On 11/13/23, I conducted an exit conference the owner, Marva Townsend. She was informed of the investigative findings and aware that a corrective action plan is due within 15 days of receipt of this report.

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.
ANALYSIS:	There were no fresh fruits or vegetables observed in the home. Resident B and Ms. Merrit both confirmed there should be more. Therefore, there is a preponderance of evidence to support the allegation.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION: While investigating the allegations listed above, it was brought to my attention that the home does not have menus posted. Ms. Merrit confirmed that the home does not have a food menu readily available. Mrs. Townsend stated that the menus are completed on a laptop and it's possible that they weren't printed and posted in the home.

On 11/23/23, I conducted an exit conference with the owner, Marva Townsend. She was informed of the investigative findings and aware that a corrective action plan is due within 15 days of receipt of this report.

APPLICABLE RULE	
R 400.14313	**Resident nutrition.**
	(4) Menus of regular diets shall be written at least 1 week in advance and posted. Any change or substitution shall be noted and considered as part of the original menu.
ANALYSIS:	On 10/9/23, I did not observe any updated menus posted in the home. Ms. Merritt also acknowledged the menus were not posted in the home. Based on this information, there is a preponderance of evidence to support the allegation.

CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION: While investigating the allegations listed above, Resident B informed me that she and other residents are given one toilet paper roll per week and use other items to wipe themselves when they run out. On 10/9/23, Ms. Merritt confirmed that residents are provided with only one roll of toilet paper per week and residents have had to use paper towel as a substitute. It should be noted that on 10/9/23, I observed sheets of paper towel ripped in half and sitting on the bathroom sink as if they were being used as a substitute for toilet paper. On 10/25/23, Mrs. Townsend denied the allegation and stated that toilet paper is always available and replaced as needed. She also added that three of the residents in the home take the toilet paper out of the bathroom.

On 11/13/23, I conducted an exit conference with the owner, Mrs. Townsend. She was informed of the investigative findings and stated that she was not aware that her staff were doing this. Mrs. Townsend is aware that a corrective action plan is due within 15 days of receipt of this report.

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:	Resident B and Ms. Merritt confirmed that residents are only given one roll of toilet paper per week. Despite Mrs. Townsend stating this is not true, a staff member and resident stated otherwise. Therefore, there is a preponderance of evidence to support the allegation as toilet paper is a necessity for residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION: While investigating the allegations listed above, Resident B informed me that there are no towels to dry her hands after using the bathroom. Ms. Merritt also confirmed that there are no towels or anything for residents to use to dry their hands. On 10/9/23, I did not observe any hand towels in the bathrooms while onsite. On 10/25/23, Mrs. Townsend stated that the hand towels are usually stored in the laundry room.

On 11/13/23, I conducted an exit conference with the owner, Marva Townsend. She was informed of the investigative finding and aware that a corrective action plan is due within 15 days of receipt of this report.

APPLICABLE RULE	
R 400.14401	**Environmental health.**
	(8) Hand-washing facilities that are provided in both the kitchen and bathroom areas shall include hot and cold water, soap, and individual towels, preferably paper towels.
ANALYSIS:	Resident B and Ms. Merritt both stated that the home does not have any hand towels in the bathroom for residents to use. While onsite on 10/9/23, I did not observe any hand towels available for the residents to use. Therefore, there is a preponderance of evidence to support the allegation.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION: While investigating the allegations listed above, I noticed that most of the smoke detectors in the home were intentionally disconnected or removed from the ceilings. I spoke to Mrs. Townsend on 10/9/23 regarding this and she stated that the smoke detectors were making a buzzing noise. Staff changed the batteries, and the smoke detectors continued to buzz. The residents were complaining about the noise, which led to staff disconnecting the smoke detectors. Mrs. Townsend was adamant that this issue has since been rectified and all smoke detectors are connected and operating correctly. I informed Mrs. Townsend that under no circumstance should she or staff remove or disconnect the smoke detectors.

On 11/13/23, I conducted an exit conference with the owner, Mrs. Townsend. She was informed of the investigative findings and aware that a corrective action plan is due within 15 days of receipt of this report.

APPLICABLE RULE	
R 400.14505	**Smoke detection equipment; location; battery replacement; testing, examination, and maintenance; spacing of detectors mounted on ceilings and walls; installation requirements for new construction, conversions and changes of category.**
	(1) At least 1 single-station, battery-operated smoke detector shall be installed at the following locations: **(a) Between the sleeping areas and the rest of the home. In homes that have more than 1 sleeping area, a smoke detector shall be installed to protect each separate sleeping area.**

	(b) On each occupied floor, in the basement, and in areas of the home that contain flame- or heat-producing equipment.
ANALYSIS:	Mrs. Townsend acknowledged that the smoke detectors throughout the home were disconnected due to a buzzing noise. While onsite on 10/9/23, I observed the smoke detectors to be disconnected. Since then, Mrs. Townsend stated that the batteries have been replaced and all smoke detectors are connected and operating correctly. Due to the smoke detectors being disconnected for an unknown period of time, there is a preponderance of evidence to support the allegation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, issuance of a provisional license is recommended for the above-cited quality of care violations. R312(4) is a repeat violation from the 12/2022 renewal licensing study report.

Anthony Mullins 11/13/2023

Anthony Mullins Date
Licensing Consultant

Approved By:

Jerry Hendrick 11/13/2023

Jerry Hendrick Date
Area Manager