GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

February 13, 2024

Connie Clauson
Fountain View Retirement Village Grant
50 S Maple Street
Grant, MI 49327

RE: License #: AH620236786
Fountain View Retirement Village Grant
50 S Maple Street
Grant, MI 49327

Dear Licensee:

Attached is the Renewal Licensing Study Report for the facility referenced above. The violations cited in the report require the submission of a written corrective action plan. 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 dates 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 home for the aged authorized representative and a date.
-

Upon receipt of an acceptable corrective action plan, a regular license will be issued. If you fail to submit an acceptable corrective action plan, disciplinary action will result.

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 feel free to contact the local office at (517) 241-1970.

Sincerely,

Lauren Wohlfert

Lauren Wohlfert, Licensing Staff
Bureau of Community and Health Systems
350 Ottawa NW Unit 13, 7th Floor
Grand Rapids, MI 49503
(616) 260-7781

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
RENEWAL INSPECTION REPORT

I. IDENTIFYING INFORMATION

License #:	AH620236786
Licensee Name:	Leisure Living Management of Grant, Inc.
Licensee Address:	Ste 200 3196 Kraft Ave SE Grand Rapids, MI 49512
Licensee Telephone #:	(616) 464-1564
Authorized Representative:	Connie Clauson
Administrator:	Sarah Maxim-Gerard
Name of Facility:	Fountain View Retirement Village Grant
Facility Address:	50 S Maple Street Grant, MI 49327
Facility Telephone #:	(231) 834-8202
Original Issuance Date:	10/01/1999
Capacity:	38
Program Type:	ALZHEIMERS AGED

II. METHODS OF INSPECTION

Date of On-site Inspection(s): 02/13/2024

Date of Bureau of Fire Services Inspection if applicable: 07/10/2023

Inspection Type: ☐Interview and Observation ☒Worksheet ☐Combination

Date of Exit Conference: 02/13/2024

No. of staff interviewed and/or observed 8
No. of residents interviewed and/or observed 17
No. of others interviewed 0 Role

- Medication pass / simulated pass observed? Yes ☒ No ☐ If no, explain.

- Medication(s) and medication records(s) reviewed? Yes ☒ No ☐ If no, explain.
- Resident funds and associated documents reviewed for at least one resident? Yes ☐ No ☒ If no, explain. No resident funds held in trust
- Meal preparation / service observed? Yes ☒ No ☐ If no, explain.

- Fire drills reviewed? Yes ☐ No ☒ If no, explain.
  Bureau of Fire Services (BFS) reviews fire drills, disaster plans reviewed with staff
- Water temperatures checked? Yes ☒ No ☐ If no, explain.

- Incident report follow-up? Yes ☐ IR date/s: N/A ☒
- Corrective action plan compliance verified? Yes ☐ CAP date/s and rule/s: N/A
- Number of excluded employees followed up? 2 N/A ☐

III. DESCRIPTION OF FINDINGS & CONCLUSIONS

This facility was found to be in non-compliance with the following rules:

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.**
ANALYSIS:	The inspection of several resident rooms revealed Resident A and Resident B had loose bed rails attached to their bedframes. In addition to the rails being loose, there were gaps between the rails and mattress causing concern for entrapment. I observed Resident C had a bed cane present. This device was between the mattress and box spring, it was not affixed to the bed frame.
CONCLUSION:	**VIOLATION ESTABLISHED**

R 325.1979	**General maintenance and storage.**
	(3) Hazardous and toxic materials shall be stored in a safe manner.
ANALYSIS:	Inspection of the oxygen tank storage revealed several canisters were not secured in the proper holsters to ensure they remained upright. Several tanks were freestanding and could fall over as they were not secured.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, renewal of the license is recommended.

02/13/2024

_____

Date

Licensing Consultant