GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

November 6, 2023

James Maxson
Grand Vista Properties, LLC
13711 Lyopawa Island
Coldwater, MI 49036

RE: License #: AL120405135
Investigation #: 2023A1032060
Grand Vista Properties II

Dear Mr. Maxson:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

Please review the enclosed documentation for accuracy and contact me with any questions. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0183.

Sincerely,

Dwight Forde, 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 #:	AL120405135
Investigation #:	2023A1032060
Complaint Receipt Date:	09/21/2023
Investigation Initiation Date:	09/26/2023
Report Due Date:	11/20/2023
Licensee Name:	Grand Vista Properties, LLC
Licensee Address:	13711 Lyopawa Island Coldwater, MI 49036
Licensee Telephone #:	(517) 227-5225
Licensee Designee:	James Maxson
Name of Facility:	Grand Vista Properties II
Facility Address:	300 Vista Drive Coldwater, MI 49036
Facility Telephone #:	(517) 227-5225
Original Issuance Date:	04/28/2021
License Status:	REGULAR
Effective Date:	10/28/2021
Expiration Date:	10/27/2023
Capacity:	20
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Residents are not being properly changed.	No
Elopement protocols were not being followed.	No
There are medication errors at the home.	No
Additional Findings	No

III. METHODOLOGY

09/21/2023	Special Investigation Intake 2023A1032060
09/26/2023	Special Investigation Initiated - On Site
09/29/2023	Contact - Document Sent
09/29/2023	Contact - Telephone call received
10/16/2023	Contact - Document Received Coldwater Police Notes
10/20/2023	Exit Conference

ALLEGATION:

Residents are not being properly changed.

INVESTIGATION:

On 9/26/23, I interviewed employee Paige Czarnecki in the home. Ms. Czarnecki denied that residents often go unchecked, and that the employees make routine

checks on things such as briefs, clothing and bedding, to make sure that residents are dry.

I interviewed employee Kaylee Smith in the home. Ms. Smith stated that she checks in on residents routinely to make sure that they are properly toileted if indicated in their plans, or she will ask residents if assistance is needed. She reported that there was a resident whose family also checks to make sure that briefs are being used up and that the sheets are being changed.

I interviewed Resident A in the home. Resident A stated that the employees make sure that she is dry, and that her bedding is changed if needed. Resident A advised that staff members do respond in a timely manner if she calls for assistance, and that her calling device is in working order.

I observed Resident A's dresser top, which had a chart for when her briefs and bedding were being changed.

APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other health care professional with regard to such items as any of the following: **(d) Other resident health care needs that can be provided in the home. The refusal to follow the instructions and recommendations shall be recorded in the resident's record.**
ANALYSIS:	Based on my interviews and observations, there is insufficient evidence to establish a violation. Resident A denied being left in soiled briefs.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Elopement protocols were not being followed.

INVESTIGATION:

On 9/26/23, employee Paige Czarnecki stated that Resident B had left the home late in the afternoon. She advised that from what she gathered, Resident B was upset with another resident after an argument and walked off the property. Ms. Czarnecki advised that about twenty minutes had passed before the staff realized that Resident B had left the premises. She advised that after a brief search, the police and the licensee designee were notified, and shortly after police arrived, Resident B was located in a nearby factory. She advised that the staff noted that Resident B was missing around 5:30PM and ultimately located around 7PM. Ms. Czarnecki stated that Resident B was escorted to the home and that she was monitored more closely. Ms. Czarnecki advised that extra alarms were placed on Resident B's door and the nearby exit, as a result of the elopement.

I interviewed Resident B in the home. Resident B stated that her memory was in decline and was unable to recall the events of the day in question, when she eloped. She was able to provide information such as her name, and her former profession.

I reviewed an incident report (IR) dated 9/18/23, which detailed the actions that employees took in response to the elopement, which included calling the police and notifying Resident B's family member.

I reviewed Resident B's Resident Care Agreement and Resident Assessment Plan. The documents did not reflect that Resident B was an elopement risk.

On 10/16/23, I received notes of police contact at the home. I was advised by Coldwater Police Department Administrative Assistant Tina Taylor, that because it was a call for service, that no actual report was written. The note states that the resident was found at 7PM.

APPLICABLE RULE	
R 400.15311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following: **(a) The death of a resident.** **(b) Any accident or illness that requires hospitalization.** **(c) Incidents that involve any of the following:** **(i) Displays of serious hostility.** **(ii) Hospitalization.**

	(iii) Attempts at self-inflicted harm or harm to others. **(iv) Instances of destruction to property.** **(d) Incidents that involve the arrest or conviction of a resident as required pursuant to the provisions of section 1403 of Act No. 322 of the Public Acts of 1988.**
ANALYSIS:	The home contacted the police once Resident B was not located and put precautions in place to increase personal monitoring and alarms to alert staff, once she was found safe, and returned to the home. There was no indication that Resident B was an elopement risk and the home could not have anticipated she would leave unsupervised.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

There are medication errors at the home.

INVESTIGATION:

On 9/26/23, employees Paige Czarnecki and Kaylee Smith stated that they were trained to pass medications. Ms. Czarnecki provided a tour of the medication room, which was locked when I entered the home.

I interviewed employee Patricia Griffin in the home. Ms. Griffin stated that she provides administrative support to the home, mainly in the area of medication administration records (MAR). Ms. Griffin stated that she typically reviews MARs to make sure that no errors have occurred, and if there are errors, she would write an incident report. She provided me with Resident B's medication administration records. I reviewed Resident B's MAR for two months and detected no inconsistencies or errors.

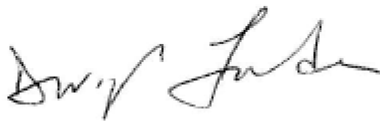
APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the

	original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being {333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	I reviewed Resident A's medication administration record and observed that the medications were properly secured in locked area.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 10/20/23, I conducted an exit conference with licensee designee James Maxon. I shared my findings and Mr. Maxon agreed with the conclusions reached.

IV. RECOMMENDATION

I recommend no change to the status of this license.



10/20/23

Dwight Forde Date
Licensing Consultant

Approved By:

11/6/23

Russell B. Misiak Date
Area Manager