GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 19, 2024

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

RE: License #: AL120405135
Investigation #: 2024A1032022
Grand Vista Properties II

Dear Mr. Maxson:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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.

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
350 Ottawa, N.W. Unit 13, 7th Floor
Grand Rapids, MI 49503

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

I. IDENTIFYING INFORMATION

License #:	AL120405135
Investigation #:	2024A1032022
Complaint Receipt Date:	02/16/2024
Investigation Initiation Date:	02/21/2024
Report Due Date:	04/16/2024
Licensee Name:	Grand Vista Properties, LLC
Licensee Address:	13711 Lyopawa Island Coldwater, MI 49036
Licensee Telephone #:	(517) 227-5225
Administrator:	James Maxson
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:	10/28/2023
Expiration Date:	10/27/2025
Capacity:	20
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
A minor was employed for direct care in the home.	Yes
Resident medications were improperly stored.	No
Additional Findings	No

III. METHODOLOGY

02/16/2024	Special Investigation Intake 2024A1032022
02/21/2024	Special Investigation Initiated - On Site
03/13/2024	Inspection Completed On-site
04/01/2024	Contact - Telephone call made Interview with former employee
04/02/2024	Contact - Document Received Email exchange with Coldwater Police Department
05/02/2024	Exit Conference
04/19/2024	Contact - Document Received Email exchange with Coldwater Police Department

ALLEGATION:

A minor was employed for direct care in the home.

INVESTIGATION:

On 2/21/24, I interviewed licensee designee James Maxon in the home. Mr. Maxson denied that a minor named Ryleigh Caudill is currently employed at the home. He stated that she was brought on as a volunteer and stated that she will turn 18 in four months. He stated that she was utilized to assist with meal preparation and housekeeping duties. He denied that she was used in direct care capacity. He stated that he had obtained guidance that he could utilize a person who was not yet eighteen. He stated that she was a good worker. He stated that she last worked at the home on the weekend of February 3, 2024.

I interviewed employee Terry Hayes in the home. Ms. Hayes reported that a minor named Ryleigh Caudill assisted her with meal prep and cleaned resident rooms under her supervision.

I reviewed the employee schedule for the month of January and early February and noted that Ryleigh Caudill's name was not on the schedule. I also noted that there was nominal compliance with the ratio of employees to residents.

On 4/1/24, employee Terry Hayes recanted her earlier statement by telephone, stating that Ryleigh Caudill did in fact work in the home, providing direct care to the residents. I asked why she did not provide this information earlier. Ms. Hayes stated that she felt pressured in the home to limit the scope of her statements, since employees are monitored.

On 4/26/24, I interviewed employee Ruby Heminger by telephone. Ms. Heminger stated that Ryleigh Caudill provided direct care to residents. She stated that they were shift partners. She posited that Ms. Caudill worked there for approximately one month and last worked in early February. She reported that Ms. Caudill did work in the kitchen as well. Ms. Heminger described their duties as toileting residents, assisting them moving from place to place and providing meals. Ms. Heminger advised that Ms. Caudill did not pass medication, as she was the designated med passer.

APPLICABLE RULE	
R 400.15204	**Direct care staff; qualifications and training.**
	(1) Direct care staff shall not be less than 18 years of age and shall be able to complete required reports and

	follow written and oral instructions that are related to the care and supervision of residents.
ANALYSIS:	Employees at the home reported that Ryleigh Caudill functioned as a direct care staff for approximately one month. This contradicts what Mr. Maxon claimed. Because more than one employee provided statements to that effect, it was reasonable to assume that a minor was employed in the home.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident medications were improperly stored.

INVESTIGATION:

On 2/21/24, Mr. Maxson denied having medications onsite for a resident who lived at Grand Vista I. He advised that the resident no longer resided at Grand Vista I and that the medications were all kept at that home. He advised that currently, there is a supply of narcotic medications for one resident at Grand Vista II.

Employee Ruby Heminger provided access to the medication room. The narcotic medication was kept in a separate locked box, and I observed a supply for Resident A.

I attempted to interview Resident A in the home, regarding the handling of his medications. Resident A did not wish to speak to me and asked that I leave his room.

I received information that in December 2023, employees reportedly submitted claims to licensee designee James Maxson that an error had occurred with Resident B's medication. I received this information after concluding my onsite inspection and this is documented in special. The error that was alleged to have occurred involved swapping two Tylenol pills with Resident B's Hydrocodone.

On 3/13/24, I interviewed licensee designee James Maxson in the home. I advised him of the new allegation. Mr. Maxson denied being advised by any employee of a medication error involving substituting medications, in December 2023. He stated that should that kind of error occur, he would write an incident report, and send it to his consultant.

I interviewed employee Erica Hurst in the home. Ms. Hurst denied being aware of any medication errors in the home and stated that once a narcotic supply is depleted, the empty pack is attached to a medication sheet.

I reviewed shift logs for the month for December and did not see any reference to a medication error. I reviewed the home's narcotics book and there were no errors noted from December 2023 to the present. I reviewed Resident B's medication administration record for the month of December, and it was apparent that Resident B was hospitalized during that period.

I interviewed Resident B in the home. Resident B was observed finishing lunch. She expressed satisfaction with her treatment in the home.

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 S333.1101 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 observed Resident A's medications to be in a locked cabinet. I reviewed Resident B's MAR for December 2023, which revealed that Resident B was not at the home during that month. I examined Resident B's current MAR, and there were no listed narcotics.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 5/2/24, I conducted an exit conference with licensee designee James Maxson. I shared my findings. Mr. Maxson was given an opportunity to provide evidence of his compliance. He agreed to submit an acceptable corrective action plan.

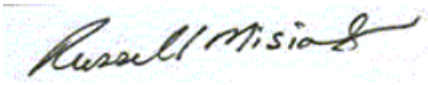
IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend no change to the status of this license.

4/19/24

Dwight Forde — Date
Licensing Consultant

Approved By:



4/30/24

Russell B. Misiak — Date
Area Manager