GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 5, 2024

Eric Simcox
Landings of Genesee Valley
4444 W. Court Street
Flint, MI 48532

RE: License #: AH250236841
Investigation #: 2024A0784061
Landings of Genesee Valley

Dear Eric Simcox:

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.

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 (517) 284-9730.

Sincerely,

Aaron L Clum

Aaron Clum, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 230-2778

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH250236841
Investigation #:	2024A0784061
Complaint Receipt Date:	05/28/2024
Investigation Initiation Date:	05/28/2024
Report Due Date:	07/27/2024
Licensee Name:	Flint Michigan Retirement Housing LLC
Licensee Address:	14005 Outlook Street Overland Park, KS 66223
Licensee Telephone #:	(240) 595-6064
Administrator/Authorized Representative:	Eric Simcox
Name of Facility:	Landings of Genesee Valley
Facility Address:	4444 W. Court Street Flint, MI 48532
Facility Telephone #:	(810) 720-5184
Original Issuance Date:	02/01/2001
License Status:	REGULAR
Effective Date:	03/07/2024
Expiration Date:	07/31/2024
Capacity:	114
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Medications not stored properly, and Resident A was not administered medication as prescribed.	Yes
Additional Findings	No

III. METHODOLOGY

05/28/2024	Special Investigation Intake 2024A0784061
05/28/2024	Special Investigation Initiated - Telephone Interview with complainant
05/31/2024	Inspection Completed On-site
06/04/2024	Contact - Document Received Additional requested documents received from regional director of operations Sera Henry
07/05/2024	Exit – Email Sent to authorized representative Eric Simcox

ALLEGATION:

INVESTIGATION:

On 5/28/2024, the department received this online complaint.

According to the complaint, two syringes of morphine were observed in a resident room unused and not stored properly and Resident A was not administered at least one dose of her prescribed morphine.

On 5/28/2024, I interviewed complainant by telephone. Complainant stated that Resident A recently passed away on 5/21/2024. Complainant stated that prior to this, Resident A's health was declining, and she was prescribed morphine for comfort measures. Complainant stated that on 5/14/2024, Associate 1 was administering a scheduled dose of morphine to Resident A and an unused syringe was observed on the table next to Resident A's bed. Complainant stated the unused syringe of morphine was supposed to be administered during the previous

scheduled dose and was not and was then not properly stored. Complainant stated Associate 1, the medication technician (med tech) at that time, was informed of the morphine that was not administered and left out. Complainant stated Associate 1 was asked to ensure the missed medication was reported and to ensure administration was aware that the medication was left out for approximately two hours. Complainant stated director of nursing Charlynn Midock and administrator Pauline Bednarick were spoken to the next day and it was discovered the medication error was never reported.

On 5/31/2024, I interviewed regional director of operations Sera Henry and resident care supervisor Laurie Wolf at the facility. Ms. Henry was present by speaker phone while Ms. Wolf was at the facility. Ms. Henry stated she was made aware of the concern on 5/30/2024 but had not had an opportunity to follow up on it. Ms. Henry stated that both Ms. Midock and Ms. Bednarick no longer work at the facility and that Associate 1 is currently on bereavement leave. Ms. Henry stated she would look into the matter further and also attempt to obtain a written statement from Associate 1.

I reviewed a written statement from Associate 1, provided by Ms. Henry. The statement read “On May 10, 2024, I [Associate 1] was scheduled on 2nd shift in building 2. [Resident A’s] daughter brought to my attention 2 syringes that was left in her room after I administered her scheduled meds. Both syringes were clear. I was unsure if they were used or not. One had the cap on the other it was off. I pushed to see if anything squirted out on my hand. I immediately went to wash my hands and finished my shift. I’m not sure if it was from 1st or 2nd shift. Someone signed for the medication, and it was not given to her. The med count was correct during the shift change”.

I reviewed Resident A’s medication administration record (MAR), provided by Ms. Henry. The MAR read consistently with statements provided by Associate 1.

APPLICABLE RULE	
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.**
R 325.1932	**Resident medications.**
	(2) The giving, taking, or applying of prescription medications shall be supervised by the home in accordance with the resident's service plan.

ANALYSIS:	The complaint alleged that Resident A was not administered morphine as prescribed and that the non-administered morphine had not been stored properly. While the date provided in Associate 1's statement varies from the complainant, the incident described by Associate 1 was consistent with the complaint and indicated that not only was Resident A not administered a dose of her medication, and the medication was not stored properly, but staff also incorrectly reported that Resident A received the medication and provided a false account of the medications left in the medication cart. Based on the findings, the facility is not in compliance with these rules.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, it is recommended that the status of the license remain unchanged.

Aaron L Clum 6/17/2024

Aaron Clum Date
Licensing Staff

Approved By:

Andrea L Moore 07/05/2024

Andrea L. Moore, Manager Date
Long-Term-Care State Licensing Section