GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 7, 2024

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

RE: License #: AL120405135
Investigation #: 2024A1032044
Grand Vista Properties II

Dear James 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.

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

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL120405135
Investigation #:	2024A1032044
Complaint Receipt Date:	08/13/2024
Investigation Initiation Date:	08/13/2024
Report Due Date:	10/12/2024
Licensee Name:	Grand Vista Properties, LLC
Licensee Address:	13711 Lyopawa Island Coldwater, MI 49036
Licensee Telephone #:	(517) 227-5225
Administrator:	James Maxson, Designee
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?
An unauthorized person is living in the home.	No
An employee assaulted Resident A, causing bruises.	No
Medications are being mishandled by employees.	No
Additional Findings	Yes

III. METHODOLOGY

08/13/2024	Special Investigation Intake 2024A1032044
08/13/2024	Special Investigation Initiated - On Site
08/13/2024	APS Referral
08/13/2024	Contact - Telephone call made I called the facility to request that resident assessment plans be sent to me by 8/14/24
08/13/2024	Contact - Telephone call received Interview with Relative A1
08/14/2024	Contact - Document Received Assessment Plans
08/20/2024	Contact - Telephone call received Interview APS Specialist Mya Kavanaugh
08/27/2024	Contact - Telephone call received Interview APS Specialist Mya Kavanaugh

09/27/2024	Contact - Document Received Email from APS Specialist Mya Kavanaugh
10/03/2024	Exit Conference

ALLEGATION:

An unauthorized person is living in the home.

INVESTIGATION:

On 8/13/24, I interviewed employee Trish Rudicill in the facility. Ms. Rudicill identified herself as the live-in employee at the facility.

I interviewed licensee James Maxson by telephone. Mr. Maxson advised that employee Trish Rudicill is a live in employee at the home. I was also advised that the home has 14 residents. The home has a licensed capacity of 20 residents.

APPLICABLE RULE	
R 400.15105	**Licensed capacity.**
	(2) Any occupant of a home other than the licensee or persons who are related to the licensee, live-in staff or the live-in staff's spouse and minor children, or the spouse of a resident who is not in need of foster care shall be considered a resident and be counted as a part of the licensed capacity.
ANALYSIS:	I was advised by both James Maxson and Trish Rudicill, that Ms. Rudicill is a live-in employee. The census stood at 14 residents, and Ms. Rudicill's presence did not affect compliance with the licensed capacity.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

An employee assaulted Resident A, causing bruises.

INVESTIGATION:

On 8/13/24, I interviewed employee Jennifer Powers in the facility. Ms. Powers denied having any interaction with Resident A that would have left bruises on his arm. She denied being physical with Resident A in any way. She stated that Resident A of late has been somewhat aggressive, rushing at staff.

Ms. Rudicill denied seeing Ms. Powers being physical with Resident A.

I asked for any recent incident reports documenting Resident A's aggression but I was told that there were none found.

Mr. Maxson stated that Resident A suffers from dementia and has been aggressive toward staff. He denied that employees had assaulted Resident A or that any form of physical restraint had been used. He suggested that I get ahold of Resident A's power of attorney to discuss the matter further and provided contact information.

I interviewed Administrator Dawn Carr at Grand Vista. Ms. Carr stated that she was unaware of any incident reports of Resident A showing aggression, or of an employee causing bruises. She advised that Resident A was moved from Grand Vista II to Grand Vista about three weeks ago. She reported that Resident A is in a wheel chair.

I interviewed Resident A at Grand Vista. Resident A stated that a girl grabbed his arm to pull off his bracelet, causing bruises to his right hand. He stated that after moving to Grand Vista, she was bothering him again. He stated that he likes living at Grand Vista and that the staff there are nice people.

I interviewed Relative A1 by telephone. Relative A1 stated that he is Resident A's power of attorney. He stated that recently, Resident A has been exhibiting signs of dementia and has been aggressive, showing signs of memory loss and confusion. He advised that he received a report that Resident A had triggered an alert through his bracelet, and employee Jennifer Powers went to his room to switch it off. When she reached over to disengage the device, Resident A erupted in anger. Ms. Powers reportedly told Resident A that all she was trying to do was turn off the bracelet and Resident A kicked at her. Relative A1 surmised that perhaps during this motion, Resident A may have been scratched. Relative A stated that he does not believe Resident A was physically abused. I asked if Resident A had been seen recently to determine that he may have dementia. I explained that there was an out of date health care appraisal. Relative A1 stated that Resident A does attend doctor appointments regularly and that he also helps with transportation.

On 8/20/24, I spoke with APS specialist Mya Kavanaugh by telephone. Ms. Kavanaugh advised that she was the assigned APS investigator in reference to my referral.

On 8/27/24, I spoke with Ms. Kavanaugh, who shared with me that Ms. Powers advised her that she was trying to put Resident A's alert bracelet back on his hand, after finding it on the floor. Ms. Kavanaugh also shared that Ms. Powers left the room after Resident A displayed a flash of aggression, and that Trish Rudicill was reportedly able to complete the task of replacing the bracelet.

On 9/27/24, Ms. Kavanaugh advised me via email that her APS case was closed and that no violation for physical abuse had been established.

APPLICABLE RULE	
R 400.15308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.
ANALYSIS:	Based on information gathered from a relative, as well as an investigation conducted by APS, there is insufficient evidence to establish that Resident A was mistreated by an employee.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Medications are being mishandled by employees.

INVESTIGATION:

On 8/13/24, I interviewed employee Monica Clarke in the facility. I advised Ms. Clark that I was made aware of a concern about medications not being accounted for. Ms. Clarke denied that there were any issues at the facility regarding medications. She stated that there are narcotics prescribed to two residents. I reviewed the Medication Administration Record for the two residents in question and reconciled the document

with the medications. There were no discrepancies. The medications were in their original packaging.

Ms. Rudicill advised that when narcotics are passed, there are two employees who review the MAR and the pill count, to ensure accountability.

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 the narcotic medications to be properly locked. I reviewed the MARs and counted the medications. The MARs and the pill counts were reconciled. I was advised of the process in place to administer narcotics, count them and document the record. These were all in keeping with the rules.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 8/13/24, I reviewed Resident A’s health care appraisal. The document was three years old. There were no diagnoses listed on the document. I reviewed a doctor’s visit that was more recent, and dementia was not listed.

I reviewed Resident A’s assessment plan. The plan reflects behavioral control on Resident A's part. The plan was three years old.

APPLICABLE RULE	
R 400.15316	**Resident records.**
	(1) A licensee shall complete, and maintain in the home, a separate record for each resident and shall provide record information as required by the department. A resident record shall include, at a minimum, all of the following information: **(d) Health care information, including all of the following:** **(i) Health care appraisals.** **(f) Assessment plan.**
ANALYSIS:	Resident A's Health care appraisal and assessment plans were dated 2021, and not updated.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 10/3/24, I conducted an exit conference with licensee designee James Maxson, where I shared my findings. Mr. Maxson agreed to furnish the department with an acceptable corrective action plan once in receipt of the special investigation report.

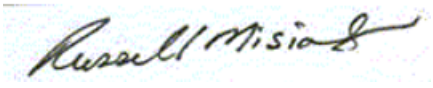
IV. RECOMMENDATION

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

10/7/24

Dwight Forde — Date
Licensing Consultant

Approved By:



10/8/24

Russell B. Misiak — Date
Area Manager