GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 30, 2024

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

RE: License #: AH250236841
Investigation #: 2024A0784095
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 #:	2024A0784095
Complaint Receipt Date:	09/23/2024
Investigation Initiation Date:	09/23/2024
Report Due Date:	11/22/2024
Licensee Name:	Flint Michigan Retirement Housing LLC
Licensee Address:	14005 Outlook Street Overland Park, KS 66223
Licensee Telephone #:	(240) 595-6064
Administrator:	Zachary Fisher
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:	08/01/2024
Expiration Date:	07/31/2025
Capacity:	114
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Inadequate supervision of Resident A	Yes
Inadequate care of Resident B	No
Additional Findings	Yes

III. METHODOLOGY

09/23/2024	Special Investigation Intake 2024A0784095
09/23/2024	Special Investigation Initiated - Letter APS Referral
09/23/2024	APS Referral
09/23/2024	Inspection Completed On-site
09/23/2024	Exit - Onsite Conduct with operations director Sera Henry

ALLEGATION:

Inadequate supervision of Resident A

INVESTIGATION:

On 9/23/2024, the department received this online complaint. Due to the anonymous nature of the complaint, additional information could not be obtained.

According to the complaint, Resident A has had multiple falls without additional measures put in place for his safety.

On 9/23/2024, I interviewed operations manager Sera Henry at the facility. Ms. Henry stated Resident A has lived at the facility since 3/12/2021. Ms. Henry stated Resident A was independent with transfers when he came to the facility. Ms. Henry stated Resident has declined over the past several months in his ability to transfer on his own. Ms. Henry stated Resident A is on hospice. Mr. Henry stated Resident A currently requires staff assistance with transfers due to being a high fall risk. Ms. Henry stated Resident A does attempt to transfer on his own. Ms. Henry stated

Resident A is a person diagnosed with Dementia and can be forgetful. Ms. Henry stated a bed alarm has been placed on Resident A's bed in order to notify staff when he is moving. Ms. Henry stated Resident A has had a recent fall after attempting to get out of bed.

On 9/23/2024, I interviewed Associate 1 at the facility. Ms. Henry was present for the interview. Associate 1 stated she provides physical therapy (PT) for Resident A due to physical weakness. Associate 1 stated Resident A is unable to transfer on his own. Associate 1 stated she is confident that Resident A will attempt to transfer on his own without staff assistance due to his low safety awareness.

On 9/23/2024, I observed Resident A in his room. Wellness director Laurie Wolf was present during the visit. Resident A was unresponsive to an attempt to interview him. During the visit, Resident A attempted to get up out of this wheelchair on his own before Ms. Wolf intervened to ensure he did not fall.

I reviewed facility INCIDENT/ACCIDENT reports for Resident A, dated 9/17/2024 and 9/19/2024, provided by Ms. Henry. Under a section titled *Describe what happened*, the report dated 9/17/2024 read "came in to do rounds, resident was on floor said he was trying to get out of bed". Under the same section, the report dated 9/19/2024 read "walked in room and he was sitting on floor. Tried to get out of bed".

I reviewed Resident A's service plan, dated 8/15/2024, provided by Ms. Henry. Under a section titled Ambulation/Transfers, the plan read, in part, "Staff to stand by and assist if needed for transfers. Has a bed alarm and chair alarm to be used. Encourage pull cord when needing help". The service plan did not indicate hospice involvement in Resident A's care.

I reviewed August and September 2024 hospice Skilled Nursing Notes, for Resident A, provided by Ms. Henry. Notes dated 8/28/2024 described Resident A, in part, as a person with "poor safety awareness and remains a high fall risk".

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 325.1922	**Admission and retention of residents.**
	(5) A home shall update each resident's service plan at least annually or if there is a significant change in the

	resident's care needs. Changes shall be communicated to the resident and his or her authorized representative, if any.
R 325.1901 (For Reference)	**Definitions.**
	(t) "Service plan" means a written statement prepared by the home in cooperation with a resident, the resident's authorized representative, or the agency responsible for a resident's placement, if any, that identifies the specific care and maintenance, services, and resident activities appropriate for the individual resident's physical, social, and behavioral needs and well-being, and the methods of providing the care and services while taking into account the preferences and competency of the resident.
ANALYSIS:	The complaint alleged Resident A had fallen several times and that no additional measures put in place for his safety. Staff reported Resident A as being a person who is a high fall risk with low safety awareness which was also the determination of hospice according to hospice notes reviewed. It is also notable that while onsite during the investigation, Resident A was observed attempting to stand up on his own. Facility incident reports indicated Resident A had falls on 9/17/2024 and 9/19/2024, both while attempting to get out of bed independently. Review of Resident A's service plan revealed that despite being a person at high risk for falling and with a low safety awareness who had at least two falls in two days, no additional measures were put in place for his safety. Additionally, while Resident A had active services from hospice, his service plan was noticeably absent of any information pertaining to hospice involvement in his care. Based on the findings, the facility is not compliant with these rules.
CONCLUSION:	**VIOLATION ESTABLISHED** **REPEAT VIOLATION: SI#2024A0784086**

ALLEGATION:

Inadequate care for Resident B

INVESTIGATION:

According to the complaint, staff are not turning and repositioning Resident B as they are supposed to.

When interviewed, Ms. Henry stated she is unaware of any issues related to Resident B's repositioning needs. Ms. Henry stated that Resident B does have an order instructing that Resident B is repositioned every two hours. Ms. Henry stated Resident B also has a tracking log in her room which staff must date and initial when completing this task. Ms. Henry stated she and Ms. Wolf consistently check these sheets and visit Resident B to ensure this task is being completed.

On 9/23/2024, I observed Resident B laying in her bed sleeping. Resident B appeared comfortable and well groomed. During the visit, Resident B's daughter was in the room and reported she had no concerns regarding Resident B's care. I Observed a small table in Resident B's room which had a sheet titled *2 HOUR TURNING PROGRAM* which Ms. Henry stated was the tracking sheet for Resident B's repositioning.

I reviewed Resident B's *Physician's Orders*, provided by Ms. Henry. Under a section titled *TREATMENT*, the orders read, "Foam turning wedges rotate patient every 2 hours with foam wedges TI prevent Skin breakdown".

I reviewed Resident B's 2 HOUR TURNING PROGRAM sheets for August and September 2024, provided by Ms. Henry. Review of the sheets revealed staff consistency in repositioning Resident B according to physician's orders.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.
ANALYSIS:	The complaint alleged staff were not repositioning Resident B as required. The investigation did not find evidence to support the allegation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION:

Under a section titled *NARRATIVE NOTES*, hospice notes dated 9/11/2024 read, in part, "I noticed Pts [Resident A] bed alarm didn't' work when he got out of bed. Turns out that the batteries were turned backwards on both the bed and chair alarm". Notes dated 9/19/2024 read, in part, "I changed out the batteries on both of Pts chair and bed alarm as they were dead".

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.**
ANALYSIS:	According to Resident A's service plan, a bed alarm and chair alarm were in place as a part of his safety plan. Review of hospice visit notes revealed that on at least two occasions, the bed and chair alarm was not working due to the batteries being in place incorrectly or dead. Review of the service plan revealed no measures put in place to ensure Resident A's equipment was working properly. Based on the findings, the facility is not in compliance with this rule.
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 10/25/2024

Aaron Clum Date
Licensing Staff

Approved By:

Andrea Moore 10/30/2024

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