



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

February 18, 2025

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

RE: License #: AH250236841
Investigation #: 2025A0585030
Landings of Genesee Valley

Dear Mr. 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.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

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. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available, and you need to speak to someone immediately, please contact the local office at (517) 284-9730.

Sincerely,

A handwritten signature in cursive script that reads "Brender Howard".

Brender Howard, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street, P.O. Box 30664
Lansing, MI 48909
(313) 268-1788
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH250236841
Investigation #:	2025A0585030
Complaint Receipt Date:	01/31/2025
Investigation Initiation Date:	01/31/2025
Report Due Date:	04/02/2025
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:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A fell off the toilet while being unsupervised and Resident A was not given medical attention.	Yes
Additional Findings	No

III. METHODOLOGY

01/31/2025	Special Investigation Intake 2025A0585030
01/31/2025	Special Investigation Initiated - Telephone Call the complainant for additional information.
02/04/2025	APS Referral A referral was made to Adult Protective Services (APS).
02/05/2025	Inspection Completed On-site Completed with observation, interview and record review.
02/05/2025	Inspection Completed-BCAL Sub. Compliance
02/19/2025	Exit Conference Conducted via email to authorized representative Eric Simcox.

ALLEGATION:

Resident A fell off the toilet while being unsupervised and Resident A was not given medical attention.

INVESTIGATION:

On 1/31/2025, a complaint was received via BCHS complaint online. The complaint alleged that on 1/29/2025, at 5:26 a.m., Resident A was taken to the bathroom and placed on the toilet by staff and the staff stepped out of the bathroom. The complaint alleged that staff was seen looking at the television and then turned back to the bathroom, glancing at Resident A before looking in the mirror. The complaint alleged that moments later you could hear Resident A falling. The complaint alleged that staff was seen putting Resident A back in the bed, even though she was apparently in pain. The complaint alleged that staff left Resident A's room at 5:40

a.m. and returned at 6:15 a.m. The complaint alleged that paramedics was not called until after 8:00 a.m.

On 1/31/2025, I contacted the complainant by telephone. The complainant statements were consistent to what was reported in the complaint. He stated that the facility never called him about Resident A falling but he called them because he saw it on the camera.

On 2/04/2025, a referral was made to Adult Protective Services (APS).

On 2/4/2025, an onsite was conducted at the facility. I interviewed Employee #1 who stated that staff was in the bathroom with a staff [Employee #2] when reached for a towel and fell. She explained that Resident A told Employee #2 that she didn't want to go to the hospital. She said that Employee #2 was with Resident A in the bathroom. She said that Resident A does not stand but she can sit in the shower chair and do it herself. She said that there is only one staff and a floater in building #4 on the midnight shift. She said there is only ten residents in building #4 which Resident A resides in. She said there are only two residents in building #4 that need assistance. Employee #1 stated that Employee #2 had all of her training before working with the residents.

On 02/07/2025, I interviewed Employee #2 by telephone. Employee #2 stated that she took Resident A to the bathroom to wash up because it was a non-shower day. She said that Resident A is not mobile, but she can wash by herself. She said that Resident A was reaching for a towel, and she fell. She said that at the time of Resident A's fall, she was gathering her things. She said that Resident A told her that her hip was hurting, and she called the nurse. She said that Resident A told her that she did not want to go to the hospital. She said that she did not call Resident A's family at that time. Her statement about staffing was consistent with Employee #1.

Service plan for Resident A reads, "One assist to set and assist, one assist to transfer to shower chair. One assist for all toileting needs. Toilet every 2-3 hours as needed."

Training documents for Employee #2 were reviewed and it showed that she had all the necessary training for caring for the needs of the residents.

The complainant shared camera footage from Resident A's fall on 1/29/2025. The video footage showed the following:

On 1/29/2025 at 5:26 a.m., staff was seen lifting Resident A out of bed and putting her in her wheelchair. She pushed her in the wheelchair to the bathroom. At 5:27:43, staff came out of the bathroom and looked at what appeared to be the television. At 5:28:15 a.m. staff glanced at the bathroom as she continues to look up at what appears to be the television. At 5:28:28, staff turns back to the

bathroom, look at the mirror and then you hear the sound of Resident A fall. The staff went toward the resident and the camera went off.

On 1/29/2025 at 5:34:57 a.m. staff put Resident A back in the bed. From the angle of the camera, I could not see staff do an assessment at that time. Resident A grimaces like she was in pain. Staff put bed covers on Resident A.

On 1/29/2025 at 8:37 a.m., 2 EMS worker was seen in Resident A's room. One of them ask her what happened, and she said that she fell off the toilet.

At 8:39:53, EMS worker put Resident A on the gurney and as they moved her, she complains of pain. As EMS did their assessment, she said "It hurt".

Staffing schedules were consistent with Employee 1's statement regarding staff on duty.

Resident A was at the hospital during the time of the onsite.

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: (c) Assure the availability of emergency medical care required by a resident.
ANALYSIS:	Resident A fell while in the bathroom. Although staff was in the bathroom with Resident A when she fell. Although Resident A complained of pain, she was not immediately taken to the hospital. Therefore, the facility did not comply with this rule.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of this license remain unchanged.

Brender d. Howard

02/19/2025

Brender Howard
Licensing Staff

Date

Approved By:

Andrea L. Moore

02/19/2025

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

Date