GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 28, 2025

Sondra Yantz
Landings of Genesee Valley
4444 W. Court Street
Flint, MI 48532

RE: License #: AH250236841
Investigation #: 2025A0784037
Landings of Genesee Valley

Dear Sondra Yantz:

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) 335-5985.

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 #:	2025A0784037
Complaint Receipt Date:	03/12/2025
Investigation Initiation Date:	03/12/2025
Report Due Date:	05/11/2025
Licensee Name:	Flint Michigan Retirement Housing LLC
Licensee Address:	14005 Outlook Street Overland Park, KS 66223
Licensee Telephone #:	(240) 595-6064
Administrator/Authorized Representative:	Sondra Yantz
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 for Resident A	Yes
Additional Findings	Yes

III. METHODOLOGY

03/12/2025	Special Investigation Intake 2025A0784037
03/12/2025	APS Referral
03/12/2025	Special Investigation Initiated - Telephone APS Referral
03/12/2025	Contact - Telephone call made Interview with complainant
03/13/2025	Exit Conference Conducted with staff 5

ALLEGATION:

Inadequate supervision for Resident A

INVESTIGATION:

On 3/12/2025, the department received this online complaint. A referral was made to adult protective services (APS).

According to the complaint, Resident A has had several falls.

On 3/12/2025, I interviewed complainant by telephone. Complainant stated Resident A is a person with poor safety awareness and a high risk for falls. Complainant stated Resident A cannot support her own weight in order to ambulate. Complainant stated Resident A is often found having either fallen or slid out of bed as she often attempts to get up on her own and has sustained bruising. Complainant stated Resident A has a camera in her room viewable by family and was observed during third shift, between the evening of 3/11/2025 and the morning of 3/12/2025, to having been on the floor approximately six times. Complainant stated staff are aware of the camera in the room. Complainant stated the belief that part of the reason

Resident A falls out of bed so often is because she is unable to summons staff for assistance with using the bathroom, which complainant stated Resident A will often attempt to do if she has urges and cannot get the attention of staff. Complainant stated Resident A often would prefer to have staff toilet her in the bathroom, but that staff, especially on third shift, will only change her brief in bed after waiting for her to go to the bathroom in her brief. Complainant stated Resident A has a pull cord in her room that could be used to summons staff, but that the cord is often placed away from her bed so she cannot reach it in order to use it.

I reviewed video footage, provided by complainant, specific to the timeframe indicated by complainant. The footage consisted of 15 short clips. When interviewed, complainant explained that the video recorder is triggered by motion explaining why the footage is broken up into small clips. The footage was consistent with complainants reporting showing Resident A on multiple occasions throughout the night on her floor next to her bed. Within the footage, staff 1 and 2 can be seen coming into Resident A's room to attend to her throughout the night. On one occasion, staff 2 can be seen taking the pull cord hanging next to Resident A's bed and putting the end piece, used to grab and pull the cord, into a small portable shelving unit next to Resident A's bed. Resident A was in her bed at this time. The shelving unit was clearly out of Resident A's reach. During one video, staff 1 acknowledged being recorded by Resident A's video while appearing to be speaking to staff 2.

On 3/13/2025, I interviewed staff 3 at the facility. Staff 3 stated she has worked for the facility as a medication technician and caretaker for several months and was very familiar with Resident A. Staff 3 stated Resident A is a person who has very low safety awareness and falls consistently. Staff 3 stated Resident A often attempts to get out of bed on her own, even though she requires staff to assist her with transfers. Staff 3 stated Resident A use to be able to transfer and ambulate on her own with her walker but has been decreasing in her ability to do so. Staff 3 stated Resident A requires staff assistance into her wheelchair and requires staff to push her in the wheelchair. Staff 3 stated Resident A requires staff assistance with toileting. Staff 3 stated Resident A will use the bathroom for toileting if staff assist her. Staff 3 stated she does assist Resident A on the toilet, if possible, but will change Resident A's brief if she has already had a bowel movement. Staff 3 acknowledged awareness of Resident A's video camera.

On 3/13/2025, I interviewed staff 4 at the facility. Staff 4 provided statements consistent with those of staff 3. Staff 4 acknowledge awareness of Resident A's video camera.

On 3/13/2025, I interviewed Resident A in her bedroom at the facility. Resident A appeared clean and appropriate. I observed Resident A to have several dark marks on her arms though it was difficult to ascertain if the marks were bruising. It was very difficult to understand Resident A as she spoke very softly and provided non-sensical answers to most of the questions asked. Resident A did clearly state "most

staff treat me well" and that "the night staff are not so great". On one side of Resident A's bed was a floor pad. On the other side of the bed Resident A's pull cord was still in the same position as previously described from the video footage.

On 3/13/2025, I interviewed staff 5, a supervisor, at the facility. Staff 5 provided statements consistent with those of staff 3 and 4 regarding Resident A's care needs, safety awareness and fall risk. Staff 5 stated Resident A has been declining in health for a few months and that her frequent falling from the bed started sometime around December 2024. Staff 5 stated this was around the time Resident A was provided with a hospital bed. Staff 5 stated Resident A's bed is adjusted to the lowest position when she is sleeping at night. Staff 5 stated Resident A often "slides" out of bed rather than falling. Staff 5 acknowledged the possibility the even with the bed in a low position, with a floor mat next to the bed, the frequent falling or sliding out of bed increasing Resident A's possibility of injury.

I reviewed Resident A's service plan, dated 8/23/2024, provided by staff 5. Under a section titled *Ambulation/Transfer*, the plan indicates Resident A is "independent" with use of a "walker". Under a section titled *Fall Risk*, the plan indicates Resident A has an "unsteady gait". Under a section titled *Toileting*, the plan indicates Resident A is "independent".

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.
For Reference: R 325.1901	**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 has had multiple falls due to a lack of adequate supervision. Interviews and evidence reviewed supported the allegation. Additionally, it is notable that while staff reported Resident A as being a person who is a high fall risk with low safety awareness, Resident A's service plan was never adjusted to adequately address her safety needs.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING:

INVESTIGATION:

Upon review of the videos provided by complainant, staff 1 and 2 can be overheard making multiple comments to Resident A during the times they went into her room and found her on the floor. Comments made by staff 2 included "I can't keep picking you up", "You gotta stop getting out of this bed", "your making my job harder than it has to be", "come on, get up, your gonna have to help!", "if you stay in this bed, you would not have to deal with this" and "you keep getting on this floor and my back is hurting" . Comments made by staff 1 included "I didn't' come back on third shift to deal with you", "Yes! I have a headache!" (said after staff 1 first said "I have a headache" to which Resident A, sounding confused said "you have a headache") and "nobody is going to keep picking you up all night". During one of the videos, staff 1 and 2 can be heard making unintelligible verbal noises as it they were disgusted after staff 1 took Resident A's brief off and discovered it had BM inside with staff 2 stating loudly "ewwww!". Additionally, each time staff 1 and 2 came into Resident A's room to change her brief, they left her on the floor while changing the brief rather than transferring her to her bed.

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 investigation revealed staff 1 and 2 did not treat Resident A with dignity. 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.

4/23/2025

Aaron Clum — Date
Licensing Staff

Approved By:

04/28/2025

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