GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 7, 2021

Louis Andriotti, Jr.
Vista Springs Wyoming LLC
Ste 110
2610 Horizon Dr. SE
Grand Rapids, MI 49546

RE: License #: AH410397992
Investigation #: 2021A1028034
Vista Springs Wyoming

Dear Mr. Andriotti, Jr.:

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 (616) 356-0100.

Sincerely,
Julie Viviano, Licensing Staff
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
Cell (616) 204-4300

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

I. IDENTIFYING INFORMATION

License #:	AH410397992
Investigation #:	2021A1028034
Complaint Receipt Date:	07/26/2021
Investigation Initiation Date:	07/28/2021
Report Due Date:	08/25/2021
Licensee Name:	Vista Springs Wyoming LLC
Licensee Address:	Ste 110 2610 Horizon Dr. SE Grand Rapids, MI 49546
Licensee Telephone #:	(616) 259-8659
Administrator:	Matthew Kempf
Authorized Representative:	Louis Andriotti, Jr.
Name of Facility:	Vista Springs Wyoming
Facility Address:	2708 Meyer Ave SW Wyoming, MI 49519
Facility Telephone #:	(616) 288-0400
Original Issuance Date:	12/10/2019
License **Status:**	REGULAR
Effective Date:	06/10/2020
Expiration Date:	06/09/2021
Capacity:	147

Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Care staff did not follow Resident A's service plan resulting in several hospitalizations.	Yes
The facility is understaffed in the memory care unit to meet the needs of the residents.	Yes

III. METHODOLOGY

07/26/2021	Special Investigation Intake 2021A1028034
07/28/2021	Special Investigation Initiated - Letter APS referral emailed to Centralized Intake
07/28/2021	APS Referral 2021A1028034 - APS referral emailed to Centralized Intake
07/28/2021	Contact – face to face Interviewed administrator, Matthew Kempf, and care staff person, Kelly Cross, at the facility.
07/28/2021	Contact – telephone call made Interviewed care staff manager, Mackenzie Ferguson, by telephone.
07/28/2021	Contact – telephone call made Interviewed the complainant by telephone.
08/25/2021	Contact – telephone call made Attempted to contact care staff Christine Pepper and Jeniene Griffin by telephone for a second time. Contact was unsuccessful.

08/27/2021	Contact – telephone call made Interviewed care staff person Sharon Walker by telephone.
08/30/2021	Contact – telephone call received Interviewed care staff Christine Pepper by telephone.
08/30/2021	Contact – telephone call made Follow-up interview by telephone with care staff manager, Mackenzie Ferguson.
08/30/2021	Contact – telephone call made Follow-up interview by telephone with the complainant.
08/30/2021	Contact – telephone call made Made third unsuccessful attempt to contact care staff Jeniene Griffin by telephone.
09/07/2021	Exit Interview

ALLEGATION:

Care staff did not follow Resident A's service plan resulting in several hospitalizations.

INVESTIGATION:

On 7/26/21, the Bureau received the allegations from the online compliant system.

On 7/26/21, I emailed an Adult Protective Services (APS) referral to Centralized Intake.

On 7/28/21, I interviewed administrator Matthew Kempf at the facility. Mr. Kempf reported Resident A has dementia, resides in the memory care unit, and requires assist with care. Mr. Kempf reported Resident A was found on the floor near the bed by a care staff person on 7/11. Mr. Kempf reported Resident A fell out of bed unassisted and staff assessed the resident for pain and took vitals, while alerting Resident A's authorized representative, and physician immediately. Upon notification of the incident, Resident A's authorized representative decided to provide transport for Resident A from the facility to the emergency room for further evaluation. Mr. Kempf reported Resident A incurred a broken arm from this fall and Resident A's care plan was updated to reflect new physician orders and increased monitoring with care routine upon return to the facility. Mr. Kempf reported Resident A then returned to the hospital again on 7/27 due to a significant change in condition

and altered mental status. Mr. Kempf reported Resident A's authorized representative and physician were notified immediately with Resident A being subsequently transported by emergency services and admitted to the hospital. At the time of this interview, Resident A had not returned from the hospital. Mr. Kempf provided me a copy of Resident A's service plan, admission contract, and medication administration record (MAR) for my review.

On 7/28/21, I interviewed care staff person (CSP), Kelly Cross at the facility. Ms. Cross reported Resident A has dementia and resides on the Lakeside hallway in the memory care unit. Ms. Cross reported Resident A often needs reminders to not get up unassisted to transfer or ambulate. Ms. Cross reported Resident A did not use the call light despite being given reminders. Ms. Cross reported she was not present when Resident A fell but heard Resident A was found on the floor by care staff on 7/11 resulting in a broken arm. Ms. Cross confirmed Resident A returned to the facility after incurring a broken arm from the fall. Ms. Cross reported she was present during the incident on 7/27 in which Resident A was sent to the hospital for demonstrated change in condition. Ms. Cross reported Resident A demonstrated shortness of breath, lethargy, and there appeared to be dried blood on Resident A's lips. However, Ms. Cross reported she is unsure if it was blood or jelly from a peanut butter and jelly sandwich left on Resident A's bedside table by the family. Ms. Cross reported staff were informed by the authorized representative that a sandwich had been left in Resident A's room prior to the incident. Ms. Cross reported it was allowed and common for the family to leave food for Resident A in Resident A's room. Ms. Cross reported Resident A "did not look well and wasn't really responding to staff like usual", so staff alerted the authorized representative and physician, with Resident A being sent to the hospital. At the time of the interview Ms. Cross reported she has not heard anything back about Resident A's current condition and that Resident A has not returned to the facility yet.

On 7/28/21, I interviewed care staff manager Mackenzie Ferguson by telephone. Ms. Ferguson's statements are consistent with Mr. Kempf's and Ms. Cross' statements. Ms. Ferguson reported it has been "a rough road" with the authorized representative concerning the overall care and service plan for Resident A. Ms. Ferguson reported the facility has tried to comply with the authorized representative care requests for Resident A, but it has been difficult. Ms. Ferguson reported the care requests from the authorized representative concerning Resident A's care and service plan include the following:

- "*Not waking [Resident A] up for dinner, to let [Resident A sleep] if [they] want*".
- Requested assistance with eating and to allow food to be left in Resident A's room in case Resident A misses dinner due to sleeping.
- "*Requesting staff to not put pants on [Resident A] because it's easier for [Resident A] to toilet and requesting not to shower or change [Resident A] during normal care".*

Ms. Ferguson reported the facility updated the authorized representative's care requests in Resident A's care plan. Ms. Ferguson provided me the communication notes between the facility and the authorized representative for my review.

I reviewed the communication notes between the facility and the authorized representative which revealed the notes are consistent with Ms. Ferguson's statements about the requested care for Resident A.

On 7/28/21, I interviewed the complainant by telephone. The complainant reported Resident A has dementia and requires increased assistance with all cares, especially since breaking their arm. The complainant reported Resident A moved into the facility in March 2021 and has been to the hospital three times prior and is now currently in the hospital due to aspiration pneumonia, seizure, and altered mental status. The complainant reported Hospice is supposed to perform an assessment later in the day to determine if services are warranted and "is afraid [Resident A] is going to pass at any moment". The complainant reported the facility has been neglectful in the care of Resident A and that Resident A has incurred several injuries to include a broken arm and ribs since being in the facility. The complainant reported the care plan has been updated several times at their "request but it doesn't matter, because they don't follow it."

On 8/27/21, I interviewed CSP Sharon Walker who reported she was not present when Resident A incurred the injuries. Ms. Walker also reported she had no further information about Resident A.

On 8/30/21, I interviewed CSP Christine Pepper by telephone. Ms. Pepper reported she worked third shift in the memory care unit and worked often with Resident A. Ms. Pepper reported Resident A resided on the Lakeside hallway and that hallway consists of residents who require little assist to verbal reminders only. Ms. Pepper reported Resident A was "independent for the most part and could use the call light but would not wait on staff when getting in and out of bed especially after the broken arm happened. [Resident A] would just get up and go no matter what care staff said." Ms. Pepper reported care staff provided verbal reminders daily for Resident A to wait for assist and care checks were preformed every two hours for Resident A. Ms. Pepper also reported there were visual reminders in Resident A's room to wait for assistance. Ms. Pepper reported after Resident A incurred the broken arm from a fall, Resident A required increased assist for dressing, feeding, bathing, and toileting. Ms. Pepper reported the family would visit often, eat dinner with Resident A in their room, assist with bathing and toileting Resident A and would put Resident A to bed sometimes. Ms. Pepper also reported the family left snacks for Resident A in the room and that residents on the Lakeside hallway are allowed to have snacks in their rooms. Ms. Pepper reported Resident A never returned to the facility and passed away shortly after being admitted to the hospital.

I completed a follow up interview with Ms. Ferguson by telephone. Ms. Ferguson reported the "residents on Lakeside hallway are considered transitional, meaning

these residents are independent to modified independent with verbal reminders." Ms. Ferguson reported Resident A was always encouraged to eat in the common dining area for appropriate monitoring. Ms. Ferguson reported Resident A would eat in their room if the authorized representative and/or family were visiting; and "the family would bring food in all the time for [Resident A]." Ms. Ferguson reported a peanut butter and jelly sandwich was found in Resident A's room the morning Resident A was sent to the hospital for altered mental status and lethargy. Ms. Ferguson reported food is allowed in the unit for the residents "as long as it is not a choking hazard or there is not a special diet involved." Ms. Ferguson reported Resident A had access to snacks, but Resident A's room had to be cleaned often because food was often left out. Ms. Ferguson reported Resident did not return to the facility and passed away in the hospital.

I completed a follow up interview with the complainant. The complainant reported Resident A passed away in the hospital on 7/29 with cause of death listed as seizure, aspiration pneumonia, and altered mental status. The complainant reported Resident A "disintegrated fast after entering the facility, within five months. I know [Resident A] had dementia and required more assist after breaking [their] arm, but I don't feel the facility did a good job taking care of [Resident A] after that happened." The complainant reported the facility reported Resident A had two toileting accidents between 3am and 4am on 7/27. The facility cleaned Resident A and assisted Resident A back to bed. The complainant reported the facility then called around 6am to let them know Resident A was found to be unresponsive during the routine two-hour care checks with Resident A being sent to the hospital then. The complainant reported the hospital reported "[Resident A] more than likely had a seizure between 4am and 6 am while at the facility." The complainant reported Resident A was checked within the two-hour window after the toileting accidents. The complainant reported they are unsure if hourly checks were completed by staff consistently. The complainant also reported assisting Resident A during their stay at the facility with bathing, toileting, dressing and feeding, especially after incurring a broken arm. The complainant reported they "did not mind assisting [Resident A] but it was obvious [Resident A] was needing more help as time when on." The complainant confirmed leaving snacks in Resident A's room.

I reviewed Resident A's most recent service plan which is dated 7/29. It revealed Resident A required the following:

- One person assist with bathing to include washing of body/hair, getting in and out of shower/tub safely.
- Assist with dressing/undressing and choosing proper attire. Use verbal cuing, give step by step direction.
- Supervision to be provided during feeding and offer guidance during meals and snacks (reminders to cut food, chew thoroughly, drink etc.)
- Assist with grooming (brushing/combing hair, shaving, applying lotion, cutting nails etc.)
- Assist with maintaining personal hygiene (washing face, applying deodorant, ensuring they are odor free etc.)

- Supervision and offer guidance with oral care. Put toothpaste on toothbrush, encourage member to brush own teeth, assist as needed.
- Assist with toileting needs (dressing/undressing, wiping, washing etc.) Check and change every 2 hours. Ensure member has brief on throughout each shift.
- Apply arm wrap in the morning and remove at night.
- Leave door open at all times.
- Assist with mobility/ambulating, Member uses cane for short distances.
- Assist with all transfers. Provide 1-person stand by assistance while member has arm sling. Encourage member to use call pendant when assistance is needed.
- Staff to frequently round on community member throughout shift. This includes passing snack or water, tidying up room, assisting to an activity, completing ADLs and when called as needed from call pendant. Wellness checks throughout night shift.

On 8/30/21, I made a third attempt to contact care staff Jeniene Griffin by telephone. I have been unsuccessful in making contact to interview her for this special investigation.

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:	While residing on Lakeside hallway in the memory care unit since March 2021, Resident A incurred several injuries to include a broken arm and rib fracture with a total of four hospitalizations. Resident expired during the last hospitalization in July 2021. Interviews with management and care staff revealed Lakeside hallway is dedicated to residents who are considered modified independent with care routine and described as highly functional and/or independent. Review of the service plan revealed: Resident A required increased supervision to one person assist and verbal cuing during all cares, transferring, and ambulation. Resident A required a higher level of care after several falls with injury. After incurring injuries, Resident A was no longer highly functional or independent. There is evidence Resident A

	demonstrated poor safety awareness by not complying with staff instruction to wait for assistance and use the call light when attempting to transfer or ambulate. I also identified through review of the service plan: Resident A required supervision be provided during feeding with guidance and reminders to cut food, chew thoroughly, drink etc. However, Resident A had food items in their room unsupervised which posed a potential risk of harm of choking. The level of care and supervision Resident A required in the most current service plan did not meet the criteria for Resident A to continue to remain on Lakeside hallway in the memory care unit. The facility should have reassessed Resident A's level of care and level of supervision after incurring several hospitalizations with demonstrated non-compliance and poor safety awareness to determine a more appropriate placement in the memory care unit with service plan for Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The facility is understaffed in the memory care unit to meet the needs of the residents.

INVESTIGATION:

On 7/28/21, Mr. Kempf reported there is currently one full time staff in the memory unit and a part time float care staff assigned to the memory care unit. Mr. Kempf reported no residents are two-person assist at this time. Mr. Kempf reported staffing is down due to the pandemic but reported the facility makes sure all shifts are covered to meet the needs of residents. Mr. Kempf reported management will assist with resident care and shift coverage if needed as well.

Ms. Cross reported the facility is short staffed, particularly on Lakeside hallway. Ms. Cross reported she "is often the only care staff person on Lakeside and it is overwhelming sometimes." Ms. Cross confirmed there are on-call/float care staff for the entire facility, but they work sporadically and "do not really work in memory care as often as needed". Ms. Cross reported "there are 12 or 13 residents in the memory care currently and none are two-person assist". Ms. Cross reported that she has "brought the need for more staffing in memory care to management's attention, but that nothing has changed so far." Ms. Cross reported there have not been a lot of call-ins recently, but when there are, care staff must find their own replacement or

shift mandation goes into effect, or management will assist to find a replacement and/or help on the floor to prevent shift shortages.

The complainant reported there is only care staff person and “they can’t do it all and watch everyone there all the time.” The complainant reported they believe Resident A incurred the prior injuries and current injuries because “they didn’t watch or help [Resident A] like they are supposed to and there really isn’t enough staff there”.

On 8/27/21, Ms. Walker reported when she works in the memory care unit, she works by herself on the hallway she is assigned and there is no other care staff person to assist. Ms. Walker reported she “does not need help in the memory care and can complete all resident care by [myself].” Ms. Walker’s statements are consistent with Ms. Cross’ statements about shift coverage, mandation, and management assisting as needed.

I reviewed the working staff schedule for May 2021 through July 2021 which revealed one care staff person assigned in the memory care unit daily during the three shifts. The review also revealed care staff working split shifts to avoid shift shortages.

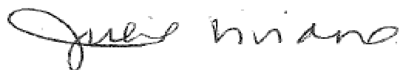
On 8/30/21, Ms. Pepper reported there is typically one person on the Lakeside hallway to perform medication administration and resident care. Ms. Pepper reported there are 10 residents currently residing on the Lakeside hallway. Ms. Pepper reported there is also a float care staff person to assist when needed and management also assists. Ms. Pepper reported the residents of Lakeside hallway need less assist than other residents in the memory care unit and there are no two-person assist on this hallway. Ms. Pepper’s statements about shift coverage and mandation are consistent with Ms. Cross’ statements and Ms. Walker’s statements.

Ms. Ferguson reported there are currently 10 residents on the Lakeside hallway and there is only one care staff person assigned to Lakeside hallway for each shift. The care staff can pass medications and provide care for the residents. There is also a float care staff person to assist as needed. Ms. Ferguson reported management will assist with resident care as needed as well. Ms. Ferguson reported Lakeside hallway residents are highly functional and require the least amount of assist in the memory care unit. Ms. Ferguson reported Lakeside hallway’s resident census never “goes over 11 because we would then need to assign another staff member there.” Ms. Ferguson also confirmed there are no residents that require two-person assist on Lakeside hallway. Ms. Ferguson’s statements about shift coverage and mandation are consistent with Ms. Cross’ statements and Ms. Pepper’s statements.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(5) The home shall have adequate and sufficient staff on duty at all times who are awake, fully dressed, and capable of providing for resident needs consistent with the resident service plans.
ANALYSIS:	Interviews with management, care staff and the complainant along with review of working staff schedules revealed one care staff person assigned to Lakeside hallway in the memory care unit for each shift. The review also revealed care staff working split shifts to prevent shift shortages. There was also minimal evidence the part-time care staff person worked on Lakeside hallway. However, given the increased level of care that Resident A required while residing on Lakeside hallway, having only one care staff person assigned to this hallway to meet the needs of all residents is not an appropriate staff to resident ratio. One care staff person cannot safely provide adequate supervision and care for all residents located on this hallway due to Resident A requiring increased care. Therefore, the facility is in violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon an acceptable corrective action plan, I recommend this license remain unchanged.



9/7/2021

Julie Viviano Date
Licensing Staff

Approved By:

9/3/21

Russell B. Misiak Date
Area Manager