GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 2, 2021

Louis Andriotti, Jr.
IP Vista Springs Timber Ridge Opco, LLC
Ste 110
2610 Horizon Dr. SE
Grand Rapids, MI 49546

RE: License #: AL190383348
Investigation #: 2021A0466047
Vista Springs Timber Ridge, LLC

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 (517) 284-9727.

Sincerely,

Julie Elkins, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL190383348
Investigation #:	2021A0466047
Complaint Receipt Date:	09/08/2021
Investigation Initiation Date:	09/09/2021
Report Due Date:	11/07/2021
Licensee Name:	IP Vista Springs Timber Ridge Opco, LLC
Licensee Address:	Ste 110 2610 Horizon Dr. SE Grand Rapids, MI 49546
Licensee Telephone #:	(303) 929-0896
Administrator:	Louis Andriotti, Jr.
Licensee Designee:	Louis Andriotti, Jr.
Name of Facility:	Vista Springs Timber Ridge, LLC
Facility Address:	16260 Park Lake Road East Lansing, MI 48823
Facility Telephone #:	(303) 929-0893
Original Issuance Date:	11/14/2016
License Status:	REGULAR
Effective Date:	05/14/2021
Expiration Date:	05/13/2023
Capacity:	20
Program Type:	AGED ALZHEIMERS

II. ALLEGATIONS:

	Violation Established?
The facility does not have adequate staffing.	Yes
The facility does not have staff trained in medication administration available to pass medications.	Yes
Residents are not being provided weekly showers.	Yes
Additional Findings	Yes

III. METHODOLOGY

09/08/2021	Special Investigation Intake 2021A0466047.
09/08/2021	Contact - Telephone call made to Complainant, interviewed.
09/09/2021	Special Investigation Initiated - On Site.
09/20/2021	Contact - Document Received additional complaint made.
09/20/2021	Contact - Telephone call made to Leslie Herrguth, assigned licensing consultant, interviewed.
09/30/2021	Contact - Telephone call made to Complainant, interviewed.
09/30/2021	Inspection Completed On-site.
10/29/2021	Exit Conference with Louis Andriotti, Jr., message left.

ALLEGATION: The facility does not have adequate staffing.

INVESTIGATION:
On 09/08/2021, Complainant reported that the facility does not have adequate staffing. Complainant reported direct care workers (DCWs) are providing care in multiple buildings. Complainant reported the facility did not have any direct care worker (DCW) in the building on 09/05/2021. Complainant reported there is one DCW per building to care for 20 residents. Complainant reported that the property has four separately licensed buildings able to admit 20 aged residents.

On 09/09/2021, I conducted an unannounced investigation and I interviewed Keith Fisher who reported the facility currently has 17 residents currently living in the facility.

On 09/09/2021, I interviewed DCW Jennifer Hatton who reported the facility is short staffed and she has worked many shifts by herself. DCW Hatton reported she was by herself today from 7am to 8am. DCW Hatton reported the DCW to resident ratios are not being met consistently. DCW Hatton reported that in the staff schedule you can see in advance that not enough DCWs are scheduled and then on top of that, there are always DCWs that call in. DCW Hatton reported that due to the low number of DCWs everyone is stretched and working a lot of hours. DCW Hatton reported the facility always has at least one DCW working, the residents are not being left alone.

On 09/09/2021, I interviewed DCW Salamatu Swaray, the second DCW on shift who reported she has never worked in the facility alone. DCW Swaray reported the residents are never left alone without a direct care staff member present.

On 09/30/2021, I interviewed Keith Fisher for a second time who reported that the facility still has 17 residents. Mr. Fischer reported that they have had DCWs call-in and they are short DCWs, but it is getting better as they have hired and are training additional DCWs. Mr. Fischer reported that the facility has never been without at least one DCW in the facility at any time. Mr. Fischer reported residents have never been left alone.

On 09/30/2021, Mr. Fisher provided me with the S*taff Schedule* which was dated 09/01/2021 through 09/30/202. The following days/times did not have two direct care staff members assigned to this facility as required given the 17 residents living in the facility during this time frame:

- 09/01/2021, 3pm-11pm
- 09/02/2021, 3pm-11pm
- 09/05/2021, 7am-3pm and 7pm-11pm
- 09/06/2021, 7am-5pm
- 09/07/2021, 7am-3pm
- 09/10/2021, 7am-3pm
- 09/11/2021, 3pm-11pm
- 09/12/2021, 7pm-11pm
- 09/13/2021, 7am-3pm
- 09/15/2021, 3pm-5pm and 9pm-11pm
- 09/16/2021, 3pm-11pm
- 09/17/2021, 7am-5pm and 9pm -11pm
- 09/18/2021, 7pm-11pm
- 09/19/2021, 7am-11pm
- 09/20/2021, 3pm-5pm and 9pm-11pm
- 09/21/2021, 3pm-5pm and 9pm-11pm

- 09/22/2021, 7am- 11pm and 3pm -5pm there was no DCW scheduled.
- 09/23/2021, 7am- 11pm and no DCW scheduled from 11p-7am.
- 09/24/2021, 3pm-5pm and 9pm-11pm
- 09/25/2021, 3pm-11pm and no DCW scheduled from 7pm-11pm
- 09/26/2021, 3pm-11pm and no DCW scheduled from 3pm-7am.
- 09/27/2021, 9pm-11pm
- 09/28/2021, 3pm-11pm and no DCW scheduled from 3pm-7am
- 09/30/2021, 3pm-11pm

On 10/27/2021, I reviewed the *Call off Report*. This facility had five call offs in September 2021. The call off occurred on the following dates/ for the following shift times:

- 09/04/2021 at 7pm
- 09/06/2021 at 7am
- 09/09/2021 at 7am
- 09/13/2021 at 7am
- 09/21/2021 at 3pm

APPLICABLE RULE	
R 400.15206	**Staffing requirements.**
	(1) The ratio of direct care staff to residents shall be adequate as determined by the department, to carry out the responsibilities defined in the act and in these rules and shall not be less than 1 direct care staff to 15 residents during waking hours or less than 1 direct care staff member to 20 residents during normal sleeping hours
ANALYSIS:	Complainant reported that on 09/05/2021, the facility did not have any DCWs in the building, however the *Staff Schedule* did show that DCWs were scheduled to work. Additionally, I reviewed the *Call off Report* and no DCWs called off on 09/05/2021. Complainant reported that the facility does not have adequate staffing. A review of the *Staff Schedule* dated 09/01/2021 through 09/30/2021 showed that 35 times the facility only had one DCW worker scheduled even though the facility had 17 residents living in the facility which required two direct care workers during waking hours, therefore it has been determined that the facility not have adequate staffing ratios.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: The facility does not have staff trained in medication administration available to pass medications.

INVESTIGATION:
On 09/08/2021, Complainant reported the facility does not have adequate staffing, with staff providing care in multiple buildings resulting in late or missed medication passes.

On 09/08/2021, Complainant reported the property has four separately licensed buildings each able to admit 20 aged residents. Complainant reported that not all DCWs are trained in medication administration and therefore residents are left in pain when there is not a trained direct care staff member available to administer medication to residents.

On 09/09/2021, I interviewed DCW Hatton who reported that she is not a trained in medication administration. DCW Hatton reported that the trained medication administrators are typically assigned to multiple buildings at the same time, especially on the overnight shift.

On 09/09/2021, I interviewed DCW Salamatu Swaray who reported that she is a trained in medication administration and that she has never been assigned to multiple buildings at the same time to administer medications.

On 09/30/2021, Mr. Fisher provided me with a facility *Village Directory* which contained the names and phone numbers of all of the direct care workers. The *Village Directory* identified those direct care workers who were trained in medication administration by highlighting their names in blue on the *Village Directory* sheet and direct care workers who were not trained in medication administration were highlighted in yellow. When I cross referenced the S*taff Schedule* with the *Village Directory* the following days/times did not have a direct care staff member trained in medication administration assigned to this facility and available to pass medication to the residents as needed:

- 09/02/2021, 7am-7pm
- 09/04/2021, 7am-7pm
- 09/05/2021, 7am-3pm
- 09/06/2021, 7am-7pm and 7pm-7am
- 09/09/2021, 7pm-7am
- 09/10/2021, 7am-7pm and 7pm-7am
- 09/12/2021, 11pm-7am
- 09/15/2021, 7pm-11pm and 11pm-7am
- 09/16/2021, 3pm-7am
- 09/17/2021, 7am-7pm and 7pm-7am
- 09/19/2021, 7am-7pm
- 09/21/2021, 3pm-7pm
- 09/22/2021, 3pm-11pm and 11pm-7am
- 09/23/2021, 3pm-11pm and 11pm-7am

- 09/24/2021, 3pm-11pm and 11pm-7am
- 09/26/2021, 7am-11pm and 11pm-7am
- 09/27/2021, 7pm-7am
- 09/28/2021, 3pm-11pm and 11pm-7am
- 09/30/2021, 7pm-11pm and 11pm-7am

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: (a) Be trained in the proper handling and administration of medication.
ANALYSIS:	The staff schedule documented that between 09/01/2021 through 09/302021, 29 shifts did not have an available direct care staff member trained in medication administration working in the AFC facility, therefore a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Residents are not provided with weekly showers.

INVESTIGATION:
On 09/08/2021, Complainant reported that a resident reported not having a shower in two weeks. Complainant reported that a resident was wearing overnight brief at 11AM.

On 09/09/2021, I interviewed DCW Hatton who stated resident showers are not done regularly as there is not enough time when you are working alone. DCW Hatton reported residents with hospice services receive showers from the hospice shower aid which is helpful. DCW Hatton reported DCWs are doing the best they can but are just very busy meeting all residents' needs.

On 09/09/2021, I interviewed DCW Swaray who reported all residents receive showers twice a week. DCW Swaray reported residents who are with hospice have a hospice shower aid to assist with resident showers.

On 09/09/2021, the residents were participating in an activity and declined to be interviewed.

On 09/30/2021, I reviewed the shower documentation for Resident A, Resident B, Resident C, Resident D, Resident E and Resident F. The information gathered was reviewed between 08/01/2021 through 09/30/2021. The findings are listed below:

- Resident A had a shower on 8/17/2021, 09/07/2021, 09/14/2021 and 09/16/2021.

- Resident B had a shower on 08/04/2021, 08/07/2021, 08/11/2021, 09/15/2021, 09/22/2021, and 09/29/2021.
- Resident C had showers on 08/02/2021, 08/05/2021, 09/06/2021, 09/09/2021, 09/13/2021, 09/16/2021 and 09/20/2021.
- Resident D had showers on 08/03/2021, 08/05/2021, 08/17/2021, 09/07/2021, 09/14/2021, 09/16/2021.
- Resident E had a shower on 08/02/2021.
- Resident F had shower on 08/06/2021, 08/10/2021, 08/17/2021, 08/20/2021, 08/24/2021, 08/27/2021, 08/31/2021, 09/07/2021, 09/10/2021, 09/14/2021, 09/17/2021, 09/21/2021 and 09/28/2021.

On 10/29/2021, I called the facility several times both in the morning and in the afternoon to interview residents, however every time I called, no one answered the phone.

APPLICABLE RULE	
R 400.15314	**Resident hygiene.**
	(1) A licensee shall afford a resident the opportunity, and instructions when necessary, for daily bathing and oral and personal hygiene. A licensee shall ensure that a resident bathes at least weekly and more often if necessary.
ANALYSIS:	DCW Hatton reported that working alone and being short staffed made it very difficult to assist the residents with showers. I conducted a resident record review for Resident A, Resident B, Resident C, Resident D, Resident E and Resident F and determined that only Resident F was showered weekly. Resident A, Resident B, Resident C, Resident D and Resident E had showers but had as much as 59 days in between showers. Consequently, a violation has been established.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:
On 09/09/2021, I interviewed DCW Hatton reported that due to the low number of DCWs everyone is stretched and working a lot of hours. DCW Hatton reported the facility always has at least one DCW working, the residents are not being left alone.

On 09/09/2021, I interviewed DCW Swaray who reported residents are never left alone.

On 09/30/2021, I interviewed Mr. Fischer who reported the facility has had DCWs call in and they are short DCWs. Mr. Fischer reported that the facility has never

been without at least one DCW in the facility at any time. Mr. Fischer reported that the residents have never been left alone.

On 09/30/2021, Mr. Fisher provided me with the S*taff Schedule* which was dated 09/01/2021 through 09/30/202. The following days/times did not have any direct care staff members documented on the *Staff Schedule* as required:

- 09/22/2021, no DCW from 3pm -5pm.
- 09/23/2021, no DCW scheduled from 11p-7am.
- 09/25/2021, no DCW scheduled from 7pm-11pm.
- 09/26/2021, no DCW scheduled from 3pm-7am.
- 09/28/2021, no DCW scheduled from 3pm-7am.

APPLICABLE RULE	
R 400.15208	**Direct care staff and employee records.**
	(3) A licensee shall maintain a daily schedule of advance work assignments, which shall be kept for 90 days. The schedule shall include all of the following information: **(e) Any scheduling changes.**
ANALYSIS:	DCW Hatton, DCW Swaray and Mr. Fischer all reported residents are never left alone, however on 09/22/2021, 09/23/2021, 09/25/2021, 09/26/2021 and 09/28/2021, the *Staff Schedule* documented that no DCWs were scheduled for some shifts on those dates. If the residents are not being left alone, then the facility did not update the *Staff Schedule* to show the schedule changes, therefore a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 10/29/2021, I left licensee designee Louis Andriotti, Jr. a voicemail message asking him to call me back to conduct the exit conference for this investigation.

IV. RECOMMENDATION

Upon receipt of an acceptable plan of correction, I recommend no change in the current license status.

10/29/2021

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Julie Elkins Date
Licensing Consultant

Approved By:

11/03/2021

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Dawn N. Timm Date
Area Manager