GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 28, 2021

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

RE: License #: AL190383349
Investigation #: 2021A0466046
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 #:	AL190383349
Investigation #:	2021A0466046
Complaint Receipt Date:	09/02/2021
Investigation Initiation Date:	09/07/2021
Report Due Date:	11/01/2021
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 #:	(517) 339-2322
Original Issuance Date:	11/14/2016
License Status:	REGULAR
Effective Date:	05/14/2021
Expiration Date:	05/13/2023
Capacity:	20
Program Type:	ALZHEIMERS AGED

II. ALLEGATIONS:

	Violation Established?
Resident A passed away about a week and a half ago. Do not resuscitate (DNR) paperwork could not be located and no action was taken by to resuscitate the resident.	No
The facility does not have any enough direct care workers trained in medication administration therefore the residents are not receiving their medication.	Yes
Residents are not receiving showers.	Yes
Additional Finding	Yes

III. METHODOLOGY

09/02/2021	Special Investigation Intake- 2021A0466046.
09/02/2021	Contact - Telephone call made to Complainant, no answer, and no ability to leave a message.
09/07/2021	Special Investigation Initiated – Telephone, Complainant interviewed.
09/07/2021	Contact - Telephone call made to Nurse Kelly Tacket, interviewed.
09/09/2021	Inspection Completed On-site.
09/30/2021	Inspection Completed On-site.
10/20/2021	Contact - Telephone call made to DCW Natasha Spagnuolo, interviewed.
10/20/2021	Contact - Telephone call made to DCW Sarah Parker, message left.
10/27/2021	Exit Conference- Louis Andriotti, Jr.

ALLEGATION: Resident A passed away about a week and a half ago. Do not resuscitate (DNR) paperwork could not be located and no action was taken by to resuscitate the resident.

INVESTIGATION:
On 09/02/2021, Complainant reported Resident A passed away about a week and a half prior to this complaint. Complainant report Resident A's paperwork for her Do Not (DNR) Resituate order could not be located so no action was taken to resuscitate Resident A.

On 09/07/2021, I interviewed Nurse Kelly Tacket who reported direct care worker (DCW) Natasha Spagnulo stated to her on 08/24/2021 that Resident A was not feeling well and had a low blood pressure. Nurse Tacket stated DCW Spagnulo appeared frustrated because she could not find Resident A's DNR paperwork and therefore was hesitant to contact emergency medical services (EMS) or 911. Nurse Tacket reported she instructed DCW Spagnulo to print Resident A's face sheet, call 911 and that she would be over once she was done assessing another resident. Nurse Tacket reported 911 was contacted and when they arrived Resident A was conscious, breathing on her own and had a pulse. Nurse Tacket reported Resident A was responsive to EMS and followed their directives. Nurse Tacket reported Resident A was in the process of beginning hospice care services but that was on a short hold as Resident A wanted to continue dialysis until a family member visited with her. Nurse Tacket reported Resident A had never been a full code rather she always had a DNR order in effect. Nurse Tacket was not sure why the paperwork was not in Resident A's file but reported she contacted Sparrow Hospital who confirmed that they had a copy of Resident A's DNR paperwork. Nurse Tacket reported facility direct care staff members did not begin any resuscitation measures because Resident A was alert, orientated, conscious, breathing and responding while she was at the facility. Nurse Tacket reported resuscitation measures are only used when a Resident is not breathing on their own. Nurse Tacket reported Resident A's DNR paperwork was never located at the facility. Nurse Tacket reported Resident A passed away at the hospital.

On 09/09/2021, I conducted an unannounced investigation and I reviewed Resident A's record. Resident A's record did not contain a DNR order.

On 09/09/2021, I interviewed Keith Fisher who reported that if Resident A does not have DNR paperwork in her file then she is a full code. Mr. Fischer reported that Resident A did not return to the facility as she passed away at the hospital.

On 09/30/2021, I interviewed DCW Sena Elum who reported that she came into work three hours after Resident A was transported to the hospital on 08/24/2021. DCW Elum reported that Resident A had been declining that week as she refused dialysis twice and she was refusing water.

On 09/30/2021, I interviewed DCW Alyssa Tubandt who reported the facility's internal computer system reported Resident A had a DNR order but no one at the facility could find the paperwork. DCW Tubandt reported Resident A was fine during the day on 08/24/2021 and did not have any complaints of physical pain or concern. DCW Tubandt reported Resident A had oxygen to use if she needed it to assist with her breathing.

On 10/20/2021, I interviewed DCW Natasha Spagnulo who reported she was working on 08/24/2021 and called EMS for Resident A. DCW Spagnulo reported she was coming on to shift at 7pm on 08/24/2021 and while doing rounds she went into Resident A's room and found Resident A was cold to the touch. Ms. Spagnulo also stated she could not get an oxygen level read on Resident A. DCW Spagnulo reported Resident A looked as if she was sleeping however, she was not responsive, but she was breathing and had a pulse. DCW Spagnulo reported she called 911 immediately as she was concerned because Resident A seemed to be declining fast. DCW Spagnulo reported Resident A did not require CPR as she was breathing on her own. DCW Spagnulo reported she could not locate Resident A's DNR order in her file. DCW Spagnulo reported Resident A does not like to go to the hospital and that she was in the process of being transferred to hospice care. DCW Spagnulo reported that Resident A died two days later at the hospital.

On 10/27/2021, I reviewed Resident A's *Service Plan Task* which did not document any need for additional supervision or frequent checks. Resident A's *Service Plan Task* documented that Resident A was mobile, used a walker for mobility and was able to effectively communicate her needs to others. Resident A's *Service Plan Task* documented that Resident A did require some assistance with activities of daily living.

APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.

ANALYSIS:	Nurse Tacket and DCW Spagnulo both reported that on 08/24/2021, Resident A was breathing on her own and therefore CPR was not administered to her as it was not required. DCW Spagnulo reported calling EMS because Resident A was cold and it was difficult to get an oxygen reading. Nurse Tacket and DCW Spagnulo both reported that on 08/24/2021, Resident A's DNR paperwork could not be located however it was not needed as Resident A remained breathing on her own. Immediate action was taken by calling EMS upon noticing a change in Resident A's condition, therefore there is no evidence to establish a violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: The facility does not have any enough direct care workers trained in medication administration therefore the residents are not receiving their medication.

INVESTIGATION:
On 09/02/2021, Complainant reported that there is one DCW per building to care for 20 residents. Complainant reported that the property has four separately licensed buildings that each house 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 Elum who reported she is not trained in medication administration and reported that she has worked by herself in the facility as direct care workers specifically trained in medication administration go back and forth to other licensed adult foster care (AFC) buildings located on the same property to administer medications. DCW Elum could not recall the dates that she worked without a direct care staff member trained in medication administration. DCW Elum reported that the facility was trying to work with a staffing agency but reported those direct care staff members did not show up for scheduled work shifts leaving the facility short staffed. DCW Elum reported that the facility is short staffed and DCWs are overwhelmed. DCW Elum reported resident medications are not being administered timely.

On 09/09/2021, I interviewed DCW Tubandt who reported that she is trained to pass resident medication. She reported that she has had to pass medications in more than one building during the same shift.

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, 7pm-11pm
- 09/03/2021, 7pm-7am
- 09/04/2021, 7pm-7am
- 09/06/2021, 7pm-7am
- 09/08/2021, 7pm-7am
- 09/10/2021, 7pm-7am
- 09/11/2021, 7pm-7am
- 09/13/2021, 7am-7pm
- 09/14/2021, 7am-7pm
- 09/15/2021, 7pm-7am
- 09/16/2021, 7am-7pm and 7pm-7am
- 09/17/2021, 7am-7pm and 7pm-7am
- 09/18/2021, 7am-7pm and 7pm-7am
- 09/19/2021, 7am-7pm and 7pm-7am
- 09/20/2021, 7am-7pm and 7pm-7am
- 09/21/2021, 7am-7pm
- 09/22/2021, 7am-11pm
- 09/23/2021, 7am-11pm
- 09/24/2021, 11pm-7am
- 09/26/2021, 11p-7am
- 09/27/2021, 7am-3pm and 11pm-7am.
- 09/28/2021, 7am-11pm
- 09/29/2021, 7am-3pm
- 09/30/2021, 3pm-11pm

On 10/20/2021, I interviewed DCW Spagnulo who is trained in medication administration. DCW Spagnulo reported that during the week, there are direct care staff members trained in the administration of resident medications in every licensed AFC facility but during weekend shifts the facility does not regularly have a direct care staff member trained to administer resident medication. DCW Spagnulo reported that the facility did not any direct care staff members trained in medication administration working during the week of 10/20/21 through 10/24/21. DCW Spagnulo sent me a copy of the *Weekly Schedule* dated 10/20/2021-10/24/2021. By using the same method described above, I cross referenced the facility *Village Directory* with the direct care staff member names listed on the *Weekly Schedule.* Based on this review, the facility did not have a direct care staff member trained in medication passaging assigned to this facility/available to pass medication to the residents as needed from 3pm-7am on 10/20/2021, 10/21/2021, 10/22/2021, 10/23/2021 and 10/24/2021.

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, 30 shifts did not have an available direct care staff member trained in medication passing working in the AFC facility. Additionally, the *Weekly Schedule* dated 10/20/2021-10/24/2021 documented that the facility did not have a direct care staff member trained in medication passaging assigned to this facility/available to pass medication to the residents as needed from 3pm-7am on 10/20/2021,10/21/2021,10/22/2021,10/23/2021 and 10/24/2021, therefore a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Residents are not receiving showers.

INVESTIGATION:
On 09/02/2021, Complainant reported that residents are not being provided showers.

On 09/09/2021, I interviewed DCW Elum who reported that the facility is short staffed and the direct care givers are doing the best they can to assist the residents with showers. DCW Elum reported residents are assigned shower days but with being short staffed direct care workers run out of time to assist residents with showering. DCW Elum reported some residents like showers after lunch and if time does not permit a direct care worker for assisting them at that time, that same resident will often refuse a shower later in the evening when a shower is offered.

On 09/09/2021, I interviewed DCW Tubandt who reported that she is medication passer and she does not typically assist with resident showers unless time allows. DCW Tubandt and I reviewed the shower documentation in the facilities computer and the findings are listed below:

- Resident D had a shower on 08/11/2021, 08/24/2021, and 09/07/2021.
- Resident F had a shower on 07/17/2021, 08/07/2021 and 08/19/2021.,
- Resident H had no showers documented and was admitted to the facility on 09/03/2021.
- Resident I had a shower on 07/11/2021, 07/18/2021, refused a shower on 08/11/2021 and had a shower on 08/29/2021.

On 09/09/2021, I interviewed Resident H who reported that she was not getting weekly showers.

On 09/09/2021, Resident D, Resident F and Resident I declined to be interviewed.

On 10/20/2021, I interviewed DCW Spagnulo who reported that she tried to get as many resident showers done as she could but working alone and being short staffed made it difficult for DCW Spagnulo to assist a resident with a shower because it takes up so much time.

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 Elum and DCW Spagnulo reported that working alone and being short staffed has made it very difficult to assist the residents with showers. I conducted a resident record review for Resident D, Resident F, Resident H and Resident I and determined none of these residents were showered at least weekly with as much as 12 days in between showers. Consequently, a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:
On 10/20/2021, I interviewed DCW Spagnulo who reported that on 08/24/2021, she called EMS on behalf Resident A which resulted in Resident A being hospitalized. The adult foster care licensing division was not notified of Resident A's hospitalization as a written incident report was not submitted.

APPLICABLE RULE	
R 400.15311	**Investigation and reporting of incidents, accidents, illnesses, absences, and death.**
	(1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following:

	(b) Any accident or illness that requires hospitalization.
ANALYSIS:	DCW Spagnulo reported that on 08/24/2021, she called EMS on behalf of Resident A and that resulted in Resident A being hospitalized. The adult foster care licensing division was not notified of Resident A's hospitalization as a written incident report was not submitted.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 10/27/2021, I conducted an exit conference with licensee designee Louis Andriotti, Jr. who understood the findings of the investigation. Licensee designee Andriotti reported that he would submit a corrective action plan within 15 days of receipt of the report and that he would work with the staff to make the necessary corrections.

IV. RECOMMENDATION

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

10/27/2021

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Julie Elkins Date
Licensing Consultant

Approved By:

10/28/2021

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Dawn N. Timm Date
Area Manager