GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 5, 2021

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

RE: License #: AL190383347
Investigation #: 2021A0466048
Vista Springs Timber Ridge, LLC

Dear Mr. Andriotti, Jr.:

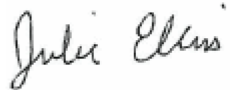
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 #:** | AL190383347 |
| | |
| **Investigation #:** | 2021A0466048 |
| | |
| **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<br>2610 Horizon Dr. SE<br>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<br>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:** | AGED<br>ALZHEIMERS |

## II. ALLEGATIONS;

| | Violation Established? |
|---|---|
| The facility does not have adequate staffing. | Yes |
| The facility does not have direct care workers trained in medication administration working in the facility. | Yes |
| Residents are not receiving showers. | Yes |
| Resident A was not administered her medications as prescribed. | Yes |

## III. METHODOLOGY

| | |
|---|---|
| 09/08/2021 | Special Investigation Intake 2021A0466048. |
| 09/08/2021 | Contact - Telephone call made to Complainant, interviewed. |
| 09/09/2021 | Special Investigation Initiated - On Site. |
| 09/30/2021 | Inspection Completed On-site. |
| 10/27/2021 | Exit Conference, call licensee designee Louis Andriotti, message left. |
| 11/01/2021 | Contact- telephone call made to DCW Ajasia Ball, interviewed. |
| 11/01/2021 | Contact- document sent to Keith Fischer. |
| 11/02/2021 | Contact- telephone call made to DCW Grace Keenan, message left. |
| 11/03/2021 | Contact- telephone call made to DCW Grace Keenan, interviewed. |
| 11/03/2021 | Contact- document received from Keith Fischer. |

**ALLEGATION: The facility does not have adequate staffing.**

**INVESTIGATION:**
On 09/08/2021, Complainant reported the facility does not have adequate staffing. Complainant reported that one direct care worker (DCW) is providing care in multiple buildings at the same time.

On 09/09/2021, I conducted an unannounced investigation and I interviewed Keith Fisher who reported that the facility currently has 13 residents 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 that 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 that the facility always has at least one DCW working, the residents are not being left alone.

On 09/30/2021, I interviewed Keith Fisher for a second time who reported that the facility still has 13 residents. Mr. Fischer reported that they have had DCWs call ins 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 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 assigned to this facility as required in the below 22 shifts.:

- 09/02/2021, 7am-7pm.
- 09/10/2021, 7am-3pm.
- 09/11/2021, 3pm-7 pm
- 09/12/2021, 7am-7pm and 7pm-11pm.
- 09/13/2021, 7pm-11pm.
- 09/14/2021, 9pm-11pm.
- 09/16/2021, 3pm-7 pm.
- 09/17/2021, 3pm -11pm
- 09/18/2021, 9pm-11pm and 11pm-7am.
- 09/21/2021, 3pm-7pm.
- 09/22/2021, 7am- 5pm.
- 09/23/2021, 3pm- 7pm.
- 09/24/2021, 7am-7pm.
- 09/26/2021, 7am-7 pm and 7pm-11pm.
- 09/27/2021, 7am-7pm and 7pm-7am.
- 09/28/2021, 3pm-5pm.
- 09/29/2021, 7pm-11pm.
- 09/30/2021, 3pm-7pm.

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

- 09/01/2021 at 7am

- 09/05/2021 at 7 am and at 7pm
- 09/07/2021 at 7am
- 09/21/2021 at 3pm
- 09/22/2021 at 7am
- 09/28/2021 at 7pm

On 09/30/2021, I interviewed Resident A who reported that the facility always has at least one DCW working at a time.  On 09/30/2021, I interviewed Kerry Toomkins, with PACE who reported that she has always seen one or two DCWs on shift while she has been in the building.

| **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:** | Although the *Staff Schedule* did not accurately document who was working on what dates during September 2021, there was no evidence residents were left unattended at any time.  Based on interviews with direct care staff members, Resident A and PACE staff, there were no times observed when residents were left unsupervised. The facility had at least one direct care staff member working which is within the required ratio given the current 13 residents living in the facility at the time of the investigation. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

| **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:**<br>**(e) Any scheduling changes.** |

| ANALYSIS: | DCW Hatton, Mr. Fischer and Resident A all reported that the residents are never left alone, however on the above 22 shifts, 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** |

**ALLEGATION: The facility does not have direct care workers trained in medication administration working in the facility.**

**INVESTIGATION:**
On 09/08/2021, Complainant reported that 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 that the property has four separately licensed buildings able to admit 20 aged residents. Complainant reported not all DCWs are trained in medication administration, so 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 those trained in medication administration 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 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:

- 09/01/2021, 7pm-7am
- 09/02/2021, 7am-7pm and 7pm to 7am
- 09/03/2021, 7pm-7am
- 09/04/2021, 7am-7pm and 7pm-7am
- 09/05/2021, 7pm-7am

- 09/06/2021, 7am-7pm
- 09/08/2021, 7am-7pm and 7pm-7am
- 09/09/2021, 7pm-7am
- 09/10/2021, 7am-7pm and 7pm-7am
- 09/11/2021, 7pm-7am.
- 09/12/2021, 7am-7pm and 7pm-7am.
- 09/13/2021, 7pm-7am
- 09/14/2021, 7pm-7am
- 09/15/2021, 7pm-7am
- 09/16/2021, 7am-7pm-7pm-7am
- 09/17/2021, 3pm-11pm and 11pm-7am
- 09/18/2021, 7pm-11pm and 11pm-7am
- 09/19/2021, 11pm-7am
- 09/21/2021, 7am-7pm
- 09/22/2021, 7am-7pm and 7pm-7am
- 09/23/2021, 7am-7pm and 7pm-7am
- 09/24/2021, 7am-7pm and 7pm-7am
- 09/25/2021, 7am-7pm and 7pm-7am
- 09/26/2021, 7am-11pm and 11pm-7am
- 09/27/2021, 7am-7pm and 7pm-7am
- 09/28/2021, 7am-7pm and 7pm-7am
- 09/29/2021, 7pm-7am
- 09/30/2021, 7am-7pm and 7pm-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:**<br>**(a) Be trained in the proper handling and administration of medication.** |
| **ANALYSIS:** | The staff schedule documented that between 09/01/2021 through 09/302021, 44 shifts did not have an available direct care staff member trained in medication passing working in the AFC facility, therefore a violation has been established. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**ALLEGATION: Residents are not receiving showers.**

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

On 09/09/2021, I interviewed DCW Hatton who 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 that the DCWs are doing the best they can they 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 receive a shower from a hospice shower aide.

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

- Resident A refused a shower on Wednesday 08/04/2021, she takes showers on Thursday.
- Resident A refused a shower on Sunday 08/15/2021.
- 08/22/2021, Saturday, Resident A recevied a shower.
- Resident A refused a shower on Sunday 08/29/2021.
- 08/30/2021, Monday, Resident A received a shower.
- Resident A refused a shower on Wednesday 09/01/2021.
- 09/24/2021, Friday, Resident A recevied a shower.

On 09/30/2021, I interviewed Resident A who reported that she is not receiving showers weekly. Resident A reported that the facility is short staffed and the DCWs run out of time to assist the residents with a shower. Resident A reported that she requires DCW assistance with a shower.

| 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 has made it very difficult to assist the residents with showers. I conducted a resident record review for Resident A and determined that Resident A was not receiving weekly showers, rather she was going anywhere from 8 days to 23 days in-between showers. Resident A was interviewed and reported that she is not receiving weekly showers and consequently, a violation has been established. |
|---|---|
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**ALLEGATION: Resident A was not administered her medications as prescribed.**

**INVESTIGATION:**
On 09/27/2021, Complainant reported that Resident A called her on 9/25/2021 indicating she had not been given her medications because they had been all been discontinued. Complainant stated Resident A was given this information by the DCW on duty. Complainant reported she called PACE to request support and did a conference call with them. Complainant reported PACE stated Resident A's medications were not discontinued. Complainant also reported PACE followed up with the facility and then called Complainant back to indicate that a DCW from the facility named Adia, last name unknown, saw that Resident A 's medications had been discontinued in the system about two to three days ago prior to this complaint. Complainant reported that the facility has done nothing to address this and therefore Resident A's medications were not administered to her as prescribed. Furthermore, Complainant reported that the facilities computer system has Resident A registered as discharged when she is still at the facility. Complainant reported Resident A stated DCW Adia was upset with Resident A for reporting this error.

On 09/30/2021, I interviewed Resident A who reported that she has not refused her medications, she reported that due to some computer "glitch" all of her medications were discontinued in the facilities computer and therefore she was not provided her medications. Resident A reported direct care staff members are not aware of which medications she has been prescribed. Resident A reported that she is a retired nurse so she is aware of the medications that have been prescribed for her and she reported that she went several days without those prescribed medications because of a computer glitch.

On 09/30/2021, I reviewed Resident A's medication administration record (MAR) which was provided to me by Keith Fischer, Senior Managing Partner. Resident A's MAR numbered the medications listed and documented that Resident A was prescribed 67 daily administered medications some of which were prescribed to be administered multiple times a day. Resident A's MAR documented that Resident A was not administered 67 prescribed medications, some of which were the same

medications scheduled to be administered multiple times a day between 09/22/2021-09/30/2021.

On 11/03/2021, I interviewed Grace Keenan, who reported that she is trained in medication administration and that she has administered medications to Resident A. DCW Keenan reported that she had taken off most of the month of September 2021 off. DCW Keenan reported returning to work on 09/26/2021 and Resident A reported all of her medications were "messed up." DCW Keenan reported she went into the computer system and Resident A no longer had a MAR in the system. DCW Keenan reported upon further investigation, the pharmacy had Resident A listed as a resident at two different licensed adult foster care (AFC) homes. DCW Keenan reported the pharmacy had deleted Resident A's MAR from the facility that they believed that she no longer lived at, however the wrong MAR was deleted, and Resident A went without her prescribed medication starting on 9/22/2021 through 09/24/2021. DCW Keenan reported that the error was fixed and Resident A was administered her medications as prescribed on 09/26/2021.

On 11/03/2021, DCW Keenan provided Resident A's September 2021 MAR which was numbered and documented that Resident A was prescribed 67 daily administered medications some of which are prescribed to be administered multiple times a day. Resident A's MAR documented that Resident A was not administered medications 09/22/2024 through 09/24/2021. Resident A's September 2021 MAR provided on 11/03/2021 by DCW Keenen was not the same as the one I was originally provided during an unannounced on-site investigation at the facility on 09/30/2021. Resident A's September 2021 MAR provided by DCW Keenan has every entry on the MAR filled with initials as well as red marking on it. Neither the initials or red markings were present on the copy provided by Keith Fischer on 09/30/2021.

On 11/03/2021, Mr. Fischer, provided me with an email authored by Dia Melhotra, Wellness Director to Tiffany Varner at HomeTown Pharmacy sent on 09/30/2021 at 3:39 PM which stated:

> *"I hope you are doing well. I am reaching out with a concern regarding [Resident A] medication profiling. There was a note about a week and a half ago that Hometown received stating that [Resident A] was supposedly noted to be discharged from ECP. At some point in this process, all of her meds were D/Ced in the system. We are wondering where that note for discharge came from. Please let me know ASAP. It was a big point of concern for us. Thank you!*

On 11/03/2021, Mr. Fischer provided me with an email authored Tiffany Varner at HomeTown Pharmacy dated 10/01/2021 at 2:42 PM which stated:

> *"We inadvertently DC'd the patient from the wrong facility. She was in our system as being an active patient at Majestic Bliss and Timber Ridge. The technician DC'd the patient from her current facility instead of Majestic Bliss. We have educated our technicians on making sure we continue to follow our processes correctly and double check before DC'ing a resident.*

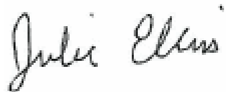
*I was wondering if someone could fax us a Census every week or two to help us keep our files current?  Our sincere apologies for this mix up and hope the patient is doing well.  Please let me know if you need any further information."*

| **APPLICABLE RULE** | |
|---|---|
| **R 400.15312** | **Resident medications.** |
| | **(2) Medication shall be given, taken, or applied pursuant to label instructions.** |
| **ANALYSIS:** | Based on review of Resident A's medication administration record and the interview with DCW Keenan, Resident A was not administered her medications as prescribed on 9/22/2021 through 09/24/2021, therefore a violation has been established. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

On 10/27/2021, 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

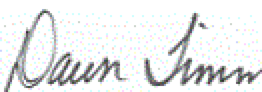
Upon receipt of an acceptable plan of correction, I recommend no change in the current license status.



11/04/2021

Julie Elkins — Date
Licensing Consultant

Approved By:



11/05/2021

Dawn N. Timm — Date
Area Manager