GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 22, 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 #: 2021A0577048
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:

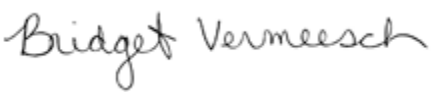
- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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.

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 (231) 922-5309.

Sincerely,



Bridget Vermeesch, Licensing Consultant
Bureau of Community and Health Systems
1919 Parkland Drive
Mt. Pleasant, MI 48858-8010
(989) 948-0561

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL190383349
Investigation #:	2021A0577048
Complaint Receipt Date:	09/30/2021
Investigation Initiation Date:	09/30/2021
Report Due Date:	11/29/2021
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:	Keith Fisher
Licensee Designee:	Louis Andriotti, Jr., Designee
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. ALLEGATION(S)

	Violation Established?
Resident A was locked out of the facility on September 15, 2021 for an unknown period of time.	Yes

III. METHODOLOGY

09/30/2021	Special Investigation Intake 2021A0577048
09/30/2021	APS Referral
09/30/2021	Special Investigation Initiated - Letter Julie Elkins, AFC Licensing Consultant provided documents regarding resident.
09/30/2021	Contact - Document Sent- Email to Ross Lauback, Clinton County Central Dispatch.
10/04/2021	Contact - Document Received- Email from Ross Lauback, Clinton Co Central Dispatch, 911 report.
10/04/2021	Contact - Telephone call made- Interview with Citizen 1.
10/07/2021	Inspection Completed On-site- Interviewed staff and residents.
10/07/2021	Inspection Completed On-site- Interview with residents and staff.
10/08/2021	Contact - Document Received- Email from Keith Fisher, Administrator with contact information for staff, staff schedules and resident assessment plan.
10/08/2021	Contact - Telephone call made- Interview with Complainant.
10/11/2021	Contact - Document Sent- Email to Keith Fisher, Admin, requesting medication training for staff and phone numbers.
10/12/2021	Contact - Telephone call made- Called Staff and left message requesting a call back.
10/12/2021	Contact - Telephone call made Interviewed DCS Brooke Baur and Madeline Bontrager.

10/20/2021	Contact - Telephone call made- Called and left messages for Janice Hill and Karla Poindexter, DCS.
10/20/2021	Contact - Telephone call made- Called and left message for DCS Aysia Ball.
10/20/2021	Contact - Telephone call made- Attempted interview with Resident G.
10/20/2021	Contact - Telephone call received- DCS Aysia Ball.
10/22/2021	Contact - Telephone call made- Attempted interview with DCS Dia Malhotra.
11/01/2021	Exit Conference with licensee designee Lou Andriotti.
11/01/2021	Inspection Completed-BCAL Sub. Compliance
11/23/2021	Exit Conference with Licensee Designee Lou Andriotti.

ALLEGATION: Resident E was locked out of the facility on September 15, 2021 for an unknown period of time.

INVESTIGATION:

On September 30, 2021 a complaint was received alleging Resident E and her dog were locked out of the facility on the night of September 15, 2021 for an unknown amount of time. The complaint reported the police came to the facility and Resident E was let back inside the facility.

On September 30, 2021, AFC licensing consultant Julie Elkins was at the facility and provided me with copies of Resident E's *Health Care Appraisal, Assessment Plan for AFC Residents, Medication Administration Record Cover Sheet, AFC Resident Information Identification Record, and Resident Record Registry Form* which documented the following information regarding Resident E.

- *Health Care Appraisal*, completed on August 12, 2020 by Dr. Roth: Resident E is diagnosed with Dementia, Depression and Hypertension; Susceptible to Hypo/Hyperthermia and related limitations-Avoid Extreme Temperature Changes.
- Resident E's *Assessment Plan for AFC Residents* was completed on August 29, 2019 and with only Relative E1's signature: Resident E is able to move independently in the community; Walking-Mobility marked yes with needs help but no additional instructions; Special Instructions-service dog 14 years old named Rocky.

- *Resident E's Service Plan Task from Electronic Medication Administration Record:*
    - Scheduled Date to start 03/02/2021-No End Date: Elopement Risk Instructions**:** Provide supervision and redirection to avoid and prevent elopement. Provide checks throughout day/night and document whereabouts. If elopement occurs, following proper elopement procedures. Status**:** Requires supervision and redirection from staff to prevent elopement episodes. Exit-seeking and requires checks throughout day/night.
    - Rocky (Dog)Instructions**:** May walk dog in fenced in area, with dog on leash, without supervision. At times [Resident E] will try to feed Rocky food that is still in the package.

On September 30, 2021 I contacted Ross Lauback, Clinton County Central Dispatch Director requesting dispatch records from September 15, 2021 regarding the 9-1-1 call and information involving the incident at the facility on that night. On October 04, 2021 I received a copy of the Clinton County Central Dispatch 9-1-1 report documenting the following:

- Clinton County 9-1-1 was contacted on September 15, 2021 at 9:45pm (21:45) by Citizen reporting [Resident E] has been locked out in a courtyard for hours and cannot find any staff in the community to let them back in, [Resident E] and dog are lockout out. When Citizen called facility, a resident answered the phone and they cannot find any staff and have been looking for over an hour. 9-1-1 called facility to try and speak to staff. Citizen reported [Resident E] is a friend of her mothers and her mother called Citizen to let her know. At 9:49pm 9-1-1 spoke with Ayasia Ball, she states she just let the resident in as she just got there for her shift, unknown what is going on.
- Spoke with shift supervisor Terresa Plank. Dayshift staff left at 7:00pm (1900 hours) without relief, no staff in building until approximately 9:45pm (2145). Teresa Plank in contact with management, has advised of situation 10:13pm (22:12).

On October 04, 2021 I interviewed Relative E1 who reported she received a call on September 17, 2021 from administrator Keith Fisher. Relative E1 reported Mr. Fisher seemed very confused during their conversation as he reported the incident involving Resident E. Relative E1 stated Mr. Fisher reported Resident E was left outside after a staff member left the facility but Resident E was not harmed. Mr. Fisher could not affirm which staff member had left the facility unattended or had not assured Resident E was indoors according to Relative E1. Relative E1 reported she contacted Relative E2 who also received a call from Mr. Fisher relaying similar information regarding Resident E. Relative E1 reported she spoke with direct care staff member Día Melhotra on September 20, 2021 who reported Resident E was left outside for an undisclosed period of time. Relative E1 reported she asked Ms. Melhotra how facility direct care staff members did not know how long Resident E was outside and Ms. Melhotra reported the

cameras at the exits/entrances did not work. Relative E1 reported Resident E no longer resided at the facility and was moved on September 20, 2021.

On October 07, 2021 I completed an unannounced onsite investigation and spoke with Administrator Keith Fisher who reported he has been conducting his own internal investigation but still had not figured out exactly what happened on the evening of September 15, 2021, with Resident E. I interviewed Colleen Cullen, Health and Wellness Officer, who reported she was just hired in this position but has been told about the incident with Resident E being locked out of the facility. Ms. Cullen showed me where Resident E's bedroom was located in the facility as well as the door Resident E used to take her dog outdoors. This door was located at the end of the same hallway as her bedroom. I observed the door and found the door is alarmed with a key code to disarm the alarm. The door can also be opened if the door handle is pushed and held 15 seconds. I observed that once the door is opened, one enters a breezeway which exits through another door leading to a fenced-in courtyard. The courtyard has sidewalks, a gazebo with table and chairs, and a yard. Ms. Cullen reported she was told Resident E was in the breezeway waiting for staff to let her back into the facility. Per Weather Underground website, www.wunderground.com, the temperature on September 15, 2021 at 9:45pm was 55 degrees Fahrenheit.

On October 07, 2021, I interviewed Resident F who reported Resident E has a dog that she walks in the courtyard multiple times throughout the day and usually the last call to walk the dog is around 8:00pm. Resident F reported on the night of September 15, 2021, Resident E could not get back into the facility through the courtyard door because the door was alarmed/locked so she let herself out of the courtyard and started knocking on resident windows asking resident, including Resident F, to let her inside the facility. Resident F reported another resident called the police to report this incident and around 10:00pm another direct care staff member came to work and found Resident E outside. Resident F reported her and another resident walked around the facility looking for staff for about an hour but could not find any staff. Resident F stated, "I believe we were without staff for at least one hour."

On October 07, 2021, I attempted to interview additional residents but due to their cognitive deficits caused by dementia they were not able to provide me with any information regarding the night of September 15, 2021.

On October 08, 2021, I interviewed Complainant who reported around 9:45pm on September 15, 2021 she received a phone call from a family member about a family friend who resides at the facility and was told there was a resident from the facility "stuck outside", who could not get back into the facility and had been outside for a long time. Complainant reported the temperature outside was about 45 degrees Fahrenheit. Complainant reported she was told residents have been looking for staff for about two and a half hours and could not find any staff. Complainant called the facility but a resident answered the telephone reporting there were not any direct care staff members in the building. Complainant reported calling 9-1-1. Complainant reported around

10:30pm she received a call from the family member reporting direct care staff had arrived and were assisting the residents with care.

On October 08, 2021 I contacted administrator Keith Fisher and requested and received a copy of the staff schedule which consists of direct care staff (DCS) and direct care staff member also trained in medication administration designated as medication technicians (MT). Mr. Fisher reported medication technicians are direct care staff trained in medication administration. The schedule for September 15, 2021 documented the following direct care staff scheduled: 7:00am-3:00pm, Madeline Bontrager, 3:00pm-11:00pm, Janice Hill, and 11:00pm-7:00am, Janice Hill and Karla Poindexter. Medication Technician/DCS scheduled from 7:00am-7:00pm was Brooke Bauer and no medication technician/DCS was scheduled from 7:00pm-7:00am.

On October 11, 2021 I interviewed Brooke Bauer, DCS-MT who reported on September 15, 2021 she worked from 7:00am-7:00pm. Ms. Bauer reported she worked with a direct care staff from 7:00am-3:00pm and then was by herself until 6:30pm when direct care staff member Dia Melhotra arrived to relieve Ms. Bauer at 7:00pm. Ms. Bauer reported she had a conversation with Ms. Melhotra and administrator Keith Fisher earlier in the day about a family emergency and they both told Ms. Bauer she could leave at 7:00pm. Ms. Bauer reported right after Ms. Melhotra arrived at the facility at 6:30pm they assisted Resident B into bed and Ms. Bauer left. Ms. Bauer reported when she finished her shift at 7:00pm, Ms. Melhotra was supposed to stay and work the floor until the next shift arrived at 11:00pm. Ms. Bauer reported she did not let Resident E and her dog outside the evening of September 15, 2021. Ms. Bauer reported she did not recall Resident E having any family or friends visit her on September 15, 2021 that would have left Resident E outside. Ms. Bauer reported the door to the fenced-in yard is alarmed and a pass code is needed to deactivate the alarm, so residents are not able to enter the yard without an alarm sounding. Ms. Bauer reported when residents are outside in the backyard, they must re-enter through the breezeway and ring the doorbell so direct care staff can let them back inside the building. Ms. Bauer did not recall the door alarm activating any time during her shift on September 15, 2021.

On October 12, 2021 I interviewed direct care staff member Madeline Bontrager who reported she worked with Brooke Bauer DCS/MT on September 15, 2021 from 7:00am-3:00pm. Ms. Bontrager reported Ms. Bauer contacted was on the telephone with direct care staff member Día Melhotra during their shift trying to figure out how they were going to staff all of the facilities for the day, specifically Gardenside due to no direct care staff training in medication administration being scheduled from 7:00pm-7:00am. Ms. Bontrager reported herself and Ms. Baur DCS/MT had a conversation about the lack of staff on the schedule and Ms. Bauer agreed to call Ms. Melhotra who is in charge of staff scheduling. Ms. Bontrager reported the direct care staff-medication technicians are scheduled as floaters between buildings but are on the schedule in the facilities who have residents that require two-person lift assist. Ms. Bontrager reported herself and Ms. Bauer did rounds first thing in the morning and Ms. Bauer administered medications. Ms. Bontrager reported when she left at 3:00pm, Ms. Bauer was the only direct care staff in the building providing care as the other scheduled direct care staff

member did not show for her 3PM shift. Ms. Bontrager reported when Resident E wants to let her dog out, she receives direct care staff assistance for this process.

On October 12, 2021and October 20, 2021 I called and left messages with direct care staff members Janice Hill and Karla Poindexter with no return call. I also called direct care staff member Aysia Ball on October 04, 2021, October 12, 2021, and October 20, 2021 with no return call.

On October 20, 2021 I attempted to interview Resident G by telephone however Resident G was not comfortable being interviewed without family with her.

On October 20, 2021 I interviewed direct care staff member Aysia Ball who reported on September 15, 2021 she was scheduled to work from 11:00pm-7:00am at Gardenside. Ms. Ball reported she showed up to work around 9:45pm and saw Resident E sitting in the breezeway needing to be let back into the facility. Ms. Ball explained Resident E will usually find a direct care staff member to help her take her dog outside, stays outside for about 15 minutes, and will then ring the bell prompting a direct care staff member to let her back inside the facility. Ms. Ball reported Resident E did not say anything to her about being outside for a long period of time at the time she helped her back inside on September 15, 2021. Ms. Ball reported however that two other residents came to her and said Resident E had been outside for over two hours because no direct care staff members were found during that time to assist Resident E back into the facility. Ms. Ball reported she walked through the facility and found no direct care staff in the building. Ms. Ball reported she started getting residents ready for bed until the direct care staff member scheduled at 11:00pm arrived.

On October 22, 2021 I interviewed direct care staff member Dia Melhotra who reported on September 15, 2021 Ms. Melhotra and Ms. Bauer, DCS/MT had a conversation about Ms. Bauer leaving at 7:00pm as long as there is another medication technician on the grounds to count medications with Ms. Bauer prior to leaving. Ms. Melhotra reported she was at Gardenside around 5:00pm to assist Ms. Bauer with feeding residents the evening meal. Ms. Melhotra reported she knew Ms. Bauer left the facility around 7:00pm but was unaware there was no other direct care staff member in the building when she (Ms. Melhotra) went to another facility on the grounds around 7:00pm. Ms. Melhotra reported prior to leaving the facility at 7:00pm she did not let Resident E outside and was not sure who let Resident E outside or when it had occurred.

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.

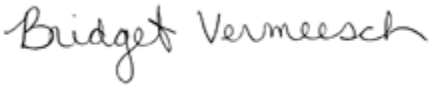
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	It has been found on September 15, 2021, the facility did not have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide services specified in each resident care agreement and assessment plan. Per a 9-1-1 recorded call on September 15, 2021 the facility did not have any direct care staff at the facility to assist Resident E who had been locked outside of the facility while caring for her dog. It is unknown how long Resident E was left outside without staff supervision during later evening hours. According to interviews, the last known direct care staff members in the building were Brooke Bauer and Dia Melhotra who were last reported to be in the facility between 6:30pm and 7:00pm. The facility remained without any direct care staff members until direct care staff member Aysia Ball arrived to work at 9:45pm. Ms. Ball stated she immediately found Resident A and her dog in the breezeway and assisted them into the facility. Ms. Ball was informed by two other residents that no direct care staff were in the building. This was affirmed after Ms. Ball searched the facility and did not find any direct care staff members. Consequently, the facility did not have any direct care staff members working for a significant period of time during the evening hours of September 15, 2021. This led to Resident E being left outdoors for an unknown period of time without supervision per her assessment plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.

ANALYSIS:	Based on the information received during the investigation it has been found the Resident E was not treated with dignity and her personal needs, including protection and safety, were not attended to at all times after Resident E was left outside by staff for an unknown amount of time and was not able to get back into the building.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon the receipt of an acceptable corrective action plan, I recommend modification of the license to provisional status.



11/22/2021

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Bridget Vermeesch Date
Licensing Consultant

Approved By:

11/22/2021

_____

Dawn N. Timm Date
Area Manager