GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 12, 2022

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

RE: License #: AL410400137
Investigation #: 2021A0357023
Vista Springs Terrace Harbor

Dear Mr. Andriotti, Jr.:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified yin 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 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,

Arlene B. Smith

Arlene B. Smith, MSW, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 916-4213

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL410400137
Investigation #:	2021A0357023
Complaint Receipt Date:	09/29/2021
Investigation Initiation Date:	09/29/2021
Report Due Date:	11/28/2021
Licensee Name:	Vista Springs Northview, LLC
Licensee Address:	Ste 110 2610 Horizon Dr. SE Grand Rapids, MI 49546
Licensee Telephone #:	(616) 364-4690
Administrator:	Susan Aalveshere
Licensee Designee:	Louis Andriotti, Jr.
Name of Facility:	Vista Springs Terrace Harbor
Facility Address:	3740 Vista Springs Ave NE Grand Rapids, MI 49525
Facility Telephone #:	(616) 364-4690
Original Issuance Date:	04/08/2020
License Status:	REGULAR
Effective Date:	10/08/2020
Expiration Date:	10/07/2022
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS, AGED

II. ALLEGATION(S)

	Violation Established?
The facility did not have enough staff to meet the residents' needs.	Yes
Staff refused to meet Resident A's care needs.	No
Resident A did not receive his medications in a timely manner.	Yes

III. METHODOLOGY

09/29/2021	Special Investigation Intake 2021A0357023
09/29/2021	Special Investigation Initiated - Telephone
09/30/2021	APS Referral
10/12/2021	Contact - Document Received Received an anonymous complaint which included the same issues in the original complaint.
10/12/2021	Contact - Telephone call received From anonymous.
10/13/2021	Contact - Telephone call received From anonymous.
10/15/2021	Contact - Telephone call made To anonymous
10/15/2021	Contact - Document Received Received an email from the Licensee Designee, Louis Andriotti Jr.
10/15/2021	Contact - Document Received Received a typed document with various concerns from Anonymous.
10/20/2021	Contact - Document Received Received email and attachments from Anonymous.
10/29/2021	Contact - Document Received from Anonymous.
11/17/2021	Contact - Document Received Received email from Licensee Designee, Louis Andriotti Jr.

12/09/2021	Inspection Completed On-site
12/09/2021	Contact - Face to Face interview with the Licensee Designee, Louis Andriotti Jr., staff Becky Balder, and Grayson Cooper. Mr. Andriotti telephoned staff Charlotte Omiljan, and on a conference call we conducted an interview with her.
12/09/2021	Contact - Document Received Received email from Louis Andriotti, the Licensee Designee and attached was a 30-day notice of discharge to Resident A.
12/10/2021	Inspection Completed On-site With the Licensee Designee Louis Andriotti, Jennifer Slater, LPN, and Direct Care Staff, Ashley Reico. Mr. Andriotti called the PA, Jennifer White, and we did an interview over the phone along with Jennifer Slater, LPN. I conducted an Interview with Resident B.
12/12/2021	Contact - Document Received Email received from Mr. Andriotti after he had met and talked with Resident B.
12/13/2021	Contact - Document Sent Email sent to Mr. Andriotti requesting staff schedules related to staffing ratios and names and telephone numbers of med passers in Vista Springs Terrace Harbor. Requested information on two-person-assist.
12/13/2021	Contact - Document Received Mr. Andriotti sent me an email that he would provide me with the requested information.
01/04/2022	Telephone call received form Mr. Andriotti and his for staff.
01/12/2022	Telephone exit conference with Mr. Adnriotti, the Licensee Designee.

On 09/29/2021 our Department, LARA, received a compliant through “Online complaints.” The complainant (Complainant #1) indicated that the facility did not have adequate staff to take care of the residents. It was also alleged that there are missing medications and medications are not refilled in a timely manner, for Resident A. Complainant #1 reported that staff will not make Resident A’s bed, won’t help him get dressed, won’t offer a shower and won’t empty his urinal. Complainant #1 also reported that staff won’t allow Resident A enough time to eat, and they take his food away before he is finished and when he tries to hold on to his

tray, they make a report that he is resistant and combative because he simply wants to eat his meal.

On 10/12/2021, our department, received an anonymous complaint that residents "never have medicine when needed." This complaint did not identify which residents did not receive their medications when they needed them, or which resident's medications were missing. I included the complaint concerning resident's lack of medications and missing medications in the original complaint and other concerns expressed by the complainant were not rule related and therefore were not investigated.

On 10/12-13/2021, I received telephone calls from four individuals who stated they would not provide their names because they were fearful of retaliation. They all reported that many staff had lost their jobs due to retaliation**.** I refer to them as Anonymous 1, Anonymous 2, Anonymous 3, and Anonymous 4. Anonymous 1, 2, 3 and 4 all stated that the facility was "short staffed" and there are two residents who require a two**-**person assist. They complained that administrative staff were not helping them get more staff and expected them to work double shifts and work when ill. They each expressed additional concerns but none of these were rule related and were therefore not investigated.

On 10/15/2021, received a typed complaint which included 14 allegations pertaining to all three licensed AFC homes for Vista Springs. On 12/10/2021, I reviewed every complaint in the document with Mr. Andriotti and Ms. Jennifer Slater, LPN and they were able to demonstrate with documentation, and verbal testimony that the allegations were either not true or not rule related. I did not open investigations on the other two licensed facilities (Vista Springs Terrace Cove or Vista Springs the Lodge). In this special investigation I included the allegations specific to Vista Springs Terrace Harbor

ALLEGATION: The facility did not have enough staff to meet the residents' needs.

INVESTIGATION: On 10/15/2021, I conducted a telephone interview with Complainant #1, who claimed to know Resident A. Complainant #1 did not want to be identified because he/she stated he/she was certain that if anyone knew who made a complaint, they would treat him worse than he has already been treated. Complainant #1 stated that there has been a change in administration, and this has caused many issues. Complainant #1 stated Resident A told him/her that when he puts his call light on the staff eventually come to his room, turn his call light off, walk out of the room without meeting any of his care needs, and the staff would say he didn't want any care. Complainant #1 stated that after speaking to Resident A on many occasions he/she was convinced that there were not enough staff to meet the needs of the residents including Resident A. Complainant #1 stated that staff are not properly trained. Complainant #1 could not provide any specific dates when the facility was short staffed but reported *"it was often."*

On 10/15/2021, I received an email from Louis Andriotti, Jr., the Licensee Designee, explaining the circumstances and reasons why the facility had been “short staffed”. Mr. Andriotti wrote that one of his leadership staff had suffered serious health issues and was not able to perform all of his normal duties. Mr. Andriotti wrote he was investigating the issues and complaints at the facility. He explained that there were three other team members who were key contributing factors to poor communication and the cause of chaos at the home. He went on to explain that staff with key positions had quit and he had terminated two staff for “*disrupting operations and making efforts to talk staff into quitting also, and three actually did*.” He wrote further that they found many things the staff were doing to cover-up issues at the home and not reporting them and this was to protect the staff who had been ill as well as protecting themselves and their jobs. He wrote *“I believe this was not all an underhanded scheme, but a group trying to do their best to team up to help their boss as a close-knit team, however, they were doing things that were not their job and causing more harm than good under the guise of helping save lives and ensure good care was provided. What they did was not all bad, however, it was wrong, and they had more personal than professional agendas. Had they reported concerns properly we could have more immediately and adequately addressed certain matters that we’ve been able to promptly, capably, and professionally address.”* His email explained all the things he has implemented. He wrote he had brought in several staff and executives from his other programs and his regional team to help. He wrote that he had appointed a new Managing Partner, Kim Vagnetti and the Administrator Susan Aalveshere would be working to help her. He acknowledged that he was still working on getting to the bottom of the entire situation. He also wrote that they would be helping Ms. Vagnetti “*clean things up*” from filing to reinstalling processes, as well as to help interview and hire new staff.

On 11/17/2021, I received an email from Mr. Andriotti. This email explained that two of his leadership staff had quit, which was another reason he was having difficulty with staffing the facility.

On 12/09/2021, I made an unannounced inspection to Vista Springs Terrace Harbor. Mr. Andriotti stated he was the new administrator of the facility. He also said that he was there to restore and repair the operations of the facility because of all the changes that had occurred in personnel. He explained that Ms. Vagentti and possibly Ms. Cox (both had quit) and other leadership staff had hired a number of employees that were either “*no call or no show,”* for their shifts along with other problems related to resident care and this was causing issues with staffing ratios. I explained I was there to investigate several issues including the facility having inadequate staff to meet the resident’s care needs.

On 12/09/2021, Mr. Androitti stated that having staff and keeping staff has been a problem and Resident A has contributed to the problem. He also explained that Ms. Barbara Cox (the former staff who quit on 11/12/2021) had hired many of her family members and these employees are often late to work, have no transportation, do not call-in if sick and just don’t show up for work and don’t notify the facility. He said

many staff have quit and he has terminated some of the staff. He stated he has not been able to secure agency staff. He also stated that many staff are working double shifts, and managers are filling in for direct care staff to meet the staffing ratios.

On 12/10/2021, I met with Mr. Andriotti for an announced inspection. He introduced me to Jennifer Slater, LPN. Ms. Slater reported that she and other administrative staff have worked the floor many times providing direct care to the residents. Mr. Andriotti confirmed that he was aware that his administrative staff have worked as direct care staff.

On 12/10/2001, I made an announced inspection of the facility. I met Resident B. I asked him about the facility staffing, and he explained that they have one care giver and one med passer on the shift. Then the med passer goes over to Vista Springs Terrace Cove to pass the residents' medications which leaves only one staff at Terrace Harbor. He explained that he requires the use of a Hoyer lift and that two staff normally help with his transfers. Resident B stated that with only one staff available he cannot be transferred. He stated he was not put to bed one evening correctly and staff never returned to his bedroom. He was unwilling to provide the staff's name to me. Resident B stated it was not until 3rd shift staff arrived to care for him that his needs were completely met. I provided this information to Mr. Andriotti and he met with Resident B and found the name of the staff that did not complete his cares. Mr. Andriotti informed me that staff no longer works at this facility.

On 12/10/2121, I spoke with Mr. Andriotti about what Resident B had shared with me and he stated they do have the med passer pass medications in both licensed facilities because their census is so low with a total of 29 residents. He stated these staff are on the schedule to work two hours in one facility and two hours in the other facility.

On 12/13/2021, I sent an email to Mr. Andriotti requesting the staff schedules from September through the current date of December 2021. I also requested the census and the number of residents requiring a two-person assist. Mr. Andriotti responded with an email on 12/13/2021 that he would gather the information and send it to me. He wrote the following "*With respect to meeting the needs of our residents and staffing we are taking the following steps:*

1. *Discharging people, we can find placement for who have high care needs 2-person assists), but we've generously given such low rental rates it's hard to find placement for them now.*
2. *Most of the care issue concerns are occurring late in the evening related to staff who won't act or do their jobs appropriately.*
3. *I'm sure others have asked LARA to allow a variance or understand the difficulty in scheduling during this period of unprecedented staffing challenges.*
4. *We have scheduled a Med-Tech to float between the Harbor and the Cove due to the low census which is only 10 in the Harbor.*
5. *I understand fully that when using a float they are supposed to be split between buildings for 2 hour increments when they are passing medications only, and*

then there is appropriate people to cover the needs of the residents during their absence from the building. We are for the most part able to have sufficient staff on the first shift, it is second shift that presents the problem and staff don't live up to their responsibilities of performing their tasks, even when they receive financial bonuses for picking up shifts and OT pay if applicable.

6. *There are just so many employee call-offs, terminations, and poor performing employees that we just can't meet the needs of the residents without having staff working OT, doing doubles (shifts) and have management work the floor. This is not a matter of not wanting to invest in higher pay rates or in obtaining supplemental agency staff, it's a matter of management and poor performing individuals simply doing some things incorrectly at times.*
7. *I would say that the residents needs are being met other than when unexpected call-offs occur or when staff members walk off the job. Again, we are working on this and have added 5 new employees but need to get rid of 5 more employees from the existing ranks also.*
8. *We have two 2-person assists in Terrace Harbor.*

We will continue to make strides every day to achieve improved performance."

On 12/16/2021, I requested the information again and he responded that he would get it to me shortly.

On 12/16/2021, I received an email with the attachments of the staffing schedules. Mr. Andriotti wrote the following: "*It seems like there are a few holes that I'm sure we were sharing (using a Float) or it could've been a new hire that was never recorded. I'm fairly confident this is correct based on discussions with employees and cross checking ECP initials."*

On 12/16/2021 I reviewed the staff schedule from 09/08/2021 through 12/14/2021. I had requested the census, but this information was not provided. Mr. Androitti had stated on 12/09/2021, that they had 10 or 11 residents in the facility, and he stated they did have two residents that require a two-person assist. When I reviewed all the staff schedules I did not find in any of the schedules that staff were working two hours in one facility.

On 09/08/2921, one staff was recorded from 6:45 AM to 3:00 and the second staff was scheduled 10:00 AM to 1:00 PM. There was no second staff from 7:00 AM to 10:00 AM and no second staff from 1:00 PM to 2:45 PM.

On 09/19/2021, one staff was scheduled from 7:00 AM to 1:00 PM. from 1:00 PM to 3:00 PM there was only one staff on duty.

On 10/17/2021, one staff was on from 6:45 AM and the second was scheduled from 11:00 to 3:00 PM. This left one staff from 6:45 AM to 11:00 AM.

On 10/20/2021, only one staff was on the schedule from 3:00 PM to 11:00 PM. One staff was scheduled 6:00 PM to 11:00 PM and this left one staff alone from 3:00 PM to 6:00 PM.

On 10/29/2021, one staff was scheduled from 2:45 PM to 11:00PM and one staff was scheduled from 5:00 PM to 11:00 PM. This left one staff on from 2:45 PM to 5:00 PM.

On 11/10/2021, only one staff was on the schedule from 6:45 AM to 3:00 PM.

On 11/21/2021, one staff was on the schedule from 7:00 AM to 3:00 PM. One staff was on the schedule from 2:45 PM to 7:00 PM. This left one staff from 7:00 PM to 11:00 PM.

On 12/04/2021, no name was on the schedule from 6:45 AM to 3:00 and only one staff was scheduled from 10:00 AM until 3:00 PM. This left no one on the schedule from 6:45 AM to 10:00 AM and then there was only one staff on the schedule from 10:00 AM to 3:00 PM.

On 12/05/2021, only one staff was recorded from 6:45 AM to 3:00 PM. and there was no one schedule for that shift. One staff for the whole shift.

On 12/06/2021, one staff was scheduled 3:00 PM to 11:00 PM. and one staff on the schedule from 6:00 PM to 11:00 PM. This left one staff alone from 3:00 PM to 6:00 PM.

On 12/08/2021, one staff was scheduled from 2:45 PM to 11:00 PM. One staff was on the schedule from 5:30 PM to 11:00 PM. This left one staff from 2:45 PM to 5:30 PM.

On 12/14/2021, one staff was on the schedule from 3:00 PM to 11:00 PM. One staff was on the schedule from 2:45 PM to 6:00 PM. This left one staff from 6:00 PM to 11:00 PM.

On 12/14/2021, I conducted a telephone interview with staff who did not want to be identified, Anymous 5. She reported that they have worked "*short staff for a long time especially in the end of October and November."* She stated she works second and third shifts. She stated that she works in Vista Springs Terrace Cove, but there were times when she has been required to pass resident's medications in Vista Springs Terrace Harbor. She was unable to provide dates for when this occurred. She stated that Harbor only had one direct care staff working on the days she passed medications. She stated that Harbor has two residents who require a two-person assist. She also stated that she has worked with one aid between Harbor and Cove and her being the only med passer in both facilities. She also reported that the staff schedule that they all see has all the shifts filled but many staff do not show

up for work or they call in and report they cannot work, and the staff schedule does not reflect these changes. She reported this has happened for a long time.

On 01/04/2022, I received a telephone call from Anymous 5. She stated that they have been working short staffed this past weekend. I asked her if any administrative staff had filled-in and she said they have never filled-in on her shifts.

On 01/04/2021, I received a telephone call from Mr. Andriotti, and four of his staff on the phone call. He said that they have been working on staff shortages and they just increased the pay to $18.00 an hour and $18.50 on the weekends. He also stated they now have two staff hired full time to do the scheduling. I explained that the staff schedules do not reflect the actual staff working in the facility because the staff schedules have not been maintained. There was acknowledgement that Becky Bolder, the staff scheduler, had not changed the staff schedules to reflect the actual staff working in the facility.

On 01/12/2021 I conducted a telephone exit conference with Mr. Louis Adnriotti Jr., the Licensee Designee and he agreed with my findings.

APPLICABLE RULE	
R 400.15206	**Staffing requirements.**
	(1) The ration 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:	Mr. Andriotti and the staff interviewed confirmed that this facility did have two residents that require a two person assist. The staff schedule indicated there have been shifts when staff worked alone in the facility. Staff reported that the schedule was not maintained to reflect who actually worked a shift. Resident B reported that the staff passing the residents' medications had to leave the facility to go to another facility to pass medications. He also reported that he had to wait util 3rd shift arrived to receive his required care needs. During this investigation there was evidence that the facility did not have the sufficient direct care staff on duty at all times.

CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION: Staff refuse to meet Resident A's care needs. More specifically, it was alleged that staff will not make his bed, won't help him get dressed, won't offer a shower, and they won't empty his urinal. In addition, staff won't allow him enough time to eat, take his food away before he is finished and when he tries to hold on to his tray, they make a report that he is resistant and combative because he simply wants to eat his meal. He puts has call light on and the staff come and shut it off and don't do anything to help him.

INVESTIGATION: On 12/10/2021 I met with Mr. Andriotti and Ms. Slater LPN. Ms. Slater supplied Resident A's care plan and his Service Plan which are on the computer for the staff to follow for his care needs. She explained that Resident A is combative, rude, name calling and obnoxious with the staff, however, no one has told her that any staff have refused to provide care for Resident A. Mr. Androitti reported that he provided a 30-day discharge notice to Resident A that included a summary of Resident A's behaviors toward staff and other residents. Mr. Andriotti has tried to have a psychological evaluation completed but Resident A refuses. They have spoken to him many times, but his behaviors continue. Ms. Slater stated he chooses to eat his meals in his bedroom rather than in the dining room with other residents.

On 12/10/2021, I reviewed Resident A's assessment plan. Resident A signed the plan on 07/15/2021. Under the section of "Social/Behavioral," the plan indicated that he could not be in the community without staff. Under the section of "Controls Aggressive Behavior," the document read that "no" he "*has verbal and physical outburst*." There was no plan designed to meet this behavior. Under the section of "Gets Along With Others," it read "no", "verbal aggressive towards others." There was no plan as to how to meet this identified need. Under the section of Self Care Skill Assessment, "the section of Eating and Feeding, both "*yes and no*" where checked and it read "*able to feed self but staff to cut up food."* Under the section of Toileting, it read yes, *"one assist on off toilet."* "*One assist with peri care*." Under bathing it read "yes" *"one assist with transfer, one assist with drying."* Under Grooming it read, "yes", *"set up assist with all grooming."* Under Dressing it read*, "*yes", *"one assist with all aspect of dressing."* Under the section of Personal Hygiene it read, "yes," *"one assist with all personal hygiene."* Under the section of Health Care Assessment, it read "yes" with "*Staff to order and administer all medication."* Under Special Diets it read, yes, *"cut food up, regular diet."* Under the section of Physical Limitations "yes" was checked and it read "*wc (wheelchair) only, unable to walk."*

On 12/10/2021, Ms. Slater provide Resident A's "Service Plan," Resident A's Diagnoses: "*Mixed hyperlipidemia, Bipolar disorder, in partial remission, most recent episode mixed, Anxiety disorder, unspecified, Polyneuropathy, unspecified, Other chronic pain, Venous insufficiency (Chronic) (Peripheral), Other specified disorders*

of veins, Spinal stenosis, cervical region, and Dysphagia, unspecified." Ms. Slater explained that all of his needs are identified in the 12/10/2021, Service Plan, and the staff are to use this document to know what his needs are and how they are to meet them. I reviewed this plan, which is extensive and thorough in defining all of Resident A's needs.

Under the Section of "Cares Provided, "*Bathing – Assistance*, ADL's/Bathing." Under this section it read, *"Provide assistance with bathing/showering (dressing/undressing, washing body/hair, drying, getting safely in and out of shower/tub etc.) Resident is a two-assist pivot transfer to shower chair and one assist with washing and drying all aspect of body. Weekly [Tues,Fri} @ 3:00 PM – 10:30 PM, as Needed."* The next section was "*Dressing – Assistance* [ADL's/Dressing]" which read *"Provide assistance with dressing/undressing and choosing proper attire. Resident is one assist with all aspects of dressing. Daily@ Wake up, Bed-Time."* The next section "*Eating – Independent [ADL's/Eating],"* which read, "*Independent with eating*." (This is different than the assessment plan.) The next section was "*Regular Diet [ADL's/Eating]" which read, "Is on a regular diet/does not have any special dietary needs."* (This is different than the assessment plan which read that the food was to be cut up.) The next section was "*Grooming – Assistance [ADL's Personal Hygiene]"* which read, *"Provide assistance with grooming (brushing/combing hair, shaving, applying lotion, cutting nails, etc.)* The next section was *"Personal Hygiene – Assistance [ADL's/Personal Hygiene]"* which read, "*Provide assistance with maintaining personal hygiene (washing face, applying deodorant, ensuring they are odor free, etc,). Resident is one assist for all aspects of personal hygiene. Daily@ Wake Up, Bed Time."* The next section was "*Oral Care – Supervision [ADL's/Oral Care],"* which read, "*Provide supervision and offer guidance with oral care. Resident is a set up assist and cue for oral care. Resident has dentures. Daily@ Wake Up, Bed Time."* The next section was "*Toileting – Assistance [ADL's/Toileting]"* which read, "*Provide assistance with toileting needs, (dressing/undressing, wiping, washing, etc.) "Resident is a one person pivot transfer on toilet and a one assist with all peri-care and incontinence. Requires staff assistance with toileting needs."* The next section was *"Assistance Devices [ADL's/Mobility and Transferring],"* which read, "*Hospital bed, manual wheelchair, motorized scooter. Maintain safety/propter use of assistive device(s)."* The next section was *"Mobility – Assistance [ADL's/Mobility and Transferring],"* which read, "*Provide assistance with mobility/ambulating. Resident can use motorized scooter independently, however, will need one assist with manual wheelchair. Daily as needed." T*he next section was *"Transferring – Assistance [ADL's/ Mobility and Transferring],"* which read *"Provide assistance with all transfers. Resident is one assist pivot transfer for all transfers, Daily@ as Needed."* The next section was "*Behavior Monitoring [Behavior Patterns/Behavior Management]"* which read, *"Chart each shift about verbal and physical outbursts, Chart when resident refuses care or has issues with compliance. Daily"….*all three shifts. The next section was "*Grand Left Toe Treatment [Physical Health/Short Term Illness],"* which read, *"Cleanse open area on left grand toe with soap and water, pat dry, apply tao, {sic} and cover with band aid every other day. Every Day @ 9:00 AM."* The other areas were "*COVID19*

Monitoring, Frequent Rounding, PCP Daily, Review of Service Plan and PCS Daily Review of Service Plan and complete charting."

On 12/09-10/2021, Mr. Andriotti introduced me to direct care staff, Ashley Rico. She stated that she tries to meet Resident A's needs, but he often refuses any help and yells at her if she offers to help him. She was aware of his needs in his assessment plan and how she was to meet his needs, but she said he refused her cares. She denied ever taking his food from him before he was finished, and she said she always answers his call light. She stated she usually works second shift, so she does not make his bed. She denied not emptying his urinal.

On 12/09/2021, Mr. Andriotti introduced me to his staff, Grayson Cooper. She stated that she works second shift full time and has been there almost two years, and she administers resident medications. She stated they do make Resident A's bed, but he does not want staff in his room. She stated for his showers, "*He does it himself and he refuses my help."* She reported that he hits staff and hides moldy food in his room. "*One day I went in this room and smelled something in his closet, and I found out he was storing fruit and apple juice in his closet so he could make his own wine*." She stated that she knew all of his care plan and all of his needs, but Resident A refuses all cares that she and others have to offer him. She denied taking his food from him before he is finished. She said staff always answer his call light and offer to help him with his needs, but he refuses their help. She said that if any of the management staff are present Resident A responds kindlier. She reported he is very smart, and he knows what he is doing.

On 12/09/2021, Mr. Andriotti telephoned the first shift staff, Charlotte Omiljan and I conducted an interview with her. She stated that Resident A will not allow staff to make his bed and he wants to go back to bed until 9:00 AM. She reported she helps him with his dressing, but he yells at her and tells her to get out of his room. She stated that he often refuses his showers and wants them at a different time. She stated she has emptied his urinal. She stated staff always allow him time to eat. She reported she buys him extra snacks in an attempt to make him happy. She also reported that he was upset one day with his breakfast, and she replaced the meal with a hot breakfast. She said one day he threw the square box from the bird feeder at her and called her stupid. He has grabbed her hand and hit her wrists. She stated that she and the other staff always answer his call light. Ms. Omiljan knew Resident A'a care plan and she said she tries to meet all his needs, but he refuses care.

Anymous 1, Anymous 2, Anymous 3, Anymous 4 and Anymous 5 all reported similar behaviors toward them by Resident A. They all stated they knew his care plan and attempted to meet his needs, but he refused cares. They were able to meet his needs when he would let them. They all denied that they took his food away from him and reported he horded his food and it got moldy.

On 12/10/2021, Ms. Slater, LPN provided the Resident A's "Care History," from 10/01/2021 thru 12/10/2021. This document was 17 pages long, which I reviewed.

The staff's initials were entered after each of his care plan requirements, demonstrating that they had completed his required care needs.

On 01/12/2022 I conducted a telephone exit conference with Mr. Andriotti, the Licensee Designee and he agreed with my findings.

APPLICABLE RULE	
R 400.15303	**Resident care; licensee responsibilities.**
	(1) Care and services that are provided to a resident by the home shall be designed to maintain and improve a resident's physical and intellectual functioning and independence. A licensee shall ensure that all interactions with residents promote and encourage cooperation, self-esteem, self-direction, independence, and normalization.
ANALYSIS:	All staff interviewed during this investigation knew Resident 's Care Plan and denied that they have refused to provide care to Resident A. They all reported he often refused care from the staff.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Resident A did not receive his medications in a timely manner. It was additionally alleged that residents' medications were not reordered in a timely manner and the staff did not have the resident's medications available when they were to be given. No other names of residents were provided.

INVESTIGATION: On 10/15/2021, I spoke by telephone with Complainant # 1. She explained that Resident A did not receive his prescribed medications because the staff did not reorder them timely, or they lost his medications. Complainant # 1 could not provide the names of the medications, the dates of the missing medications, or the names of the lost medications. Complainant # 1 stated that Resident A always counts his medications, and he knows what his medications are. Complainant #1 stated that Resident A reported this issue to Complainant #1.

On 12/09/2021, I conducted an interview with the Wellness Director, Becky Balder and Mr. Andriotti was present. She reported that she has worked direct care and passed Resident A's medications. She reported he refuses some of his medications especially his nose spray. She reported that direct care staff have reported that he refuses some of his medications. She stated that she did not know of any of his missing any of his prescribed medications except for the ones he refuses on a regular basis.

On 12/09/2021 Mr. Andriotti introduced me to one of his direct care staff, Grayson Cooper and I conducted an interview with her with Mr. Andriotti present in his office at Vista Springs Terrace Harbor. She stated that Resident A often refuses his 8:00 PM, bedtime medications. He will tell her that he will not them take them now and request that she come back at 9:30 PM or 10:00 PM. She stated she does go back and gives him his medications at the time he requested. She was unaware of any resident's meds not being reordered or the facility not having the meds to administer. She stated they chart the medications when they are administered.

On 12/09/2021 Mr. Andriotti telephoned his staff Charlotte Omiljan, first shift med passer and we conducted a telephone interview. She reported that Resident A and all the residents receive all of their prescribed medications. She was not aware of any resident medication not being reordered.

On 12/10/2021, I met with Ms. Jennifer Slater, LPN and Mr. Lou Andriotti, and we reviewed Resident A's file and Medication Administration Record (MAR's). Ms. Slater explained that Resident A insists that the NP (Nurse Practitioner) prescribe Mucinex but the resident and his "friend" refuse to pay for it. It is an over-the-counter drug and must be paid for by the resident. Ms. Slater stated that Resident A was offered all his medications, including his allergy medications, but he refuses them many times. She stated that they had made the NP aware of his refusals. This included nose spray and eye drops. As we reviewed Resident A's MAR's we found that he had refused the allergy medications on a regular basis. He had been offered them, but he refused.

On 12/10/2021, I asked Ms. Slater to pull three random resident's MAR's which she did. She pulled Resident B, Resident C, and Resident D. We reviewed them together and we could not find any of their medications that had not been administered, as evidenced by the initial of the staff on the electronic MAR for any of the three random MAR's provided.

On 12/10/2021, Mr. Andriotti telephoned the NP, Jenifer White to discuss Resident A's medications. She confirmed that Resident A has behavioral issues and that he will not accept any help from anyone especially psychological help, which has been offered. She said she was aware of the Mucinex issue. She also stated that he has artificial tears that are a PRN (as needed), but Resident A will not allow it to be a PRN. She also stated that he has allergy medications that are not critical but Resident A insists on having them. She stated she was aware of his refusals for these allergy medications. We discussed the possibility that his allergy medications be changed to being a PRN, as needed medications. Ms. White was willing to look into this and make the changes. I asked he if she was aware of any resident's medications that have not been reordered and therefore the residents did not receive them. She stated she was not aware of any issues of residents not receiving their prescribed medications.

On 12/13/2021, I reviewed Resident A's MAR's (September, October, November and part of Decedmber-2021) that Ms. Slater had provided for me.

September 2021:
On 09/07/2021, there were no staff initials on the following prescribed medications at 8:00am Aspirin 81 mg chew, Fluticasone Prop 50MCG SPR, Furosemide 20 mg tablet, Sertraline 100mg tablet, Thera-M Enhanced tablet, Tolterodine 2mg tab, Divalproex 125mg. tab, Loratadine 10mg tablet, and Triple Antibiotic ointmen {sic} There was no note that Resident A had refuse these medications. On 09/10/2021, there were no initials for Protein Shakes at 8:00am. (1 missed) On 09/16/2021, there were no initials at 5:00pm, for the Protein Shake. (1 missed). On 09/21/2021, at 5:00pm, no initial or refusal, (1 missed) and 09/30/2021, at 5:00pm, and there were no initials or refusal. (1 missed) This totaled of nine (9) prescribed medicines not administered and the Protein Share was not given four (4) times.

October 2021:
On 10/07/2021, Gabapentin 300 mg at 8:00pm was not initialed nor was there a refusal. (1 missed) On the same date at 8:00pm, there were no initials and no refusals documented for Acetaminophen 500 mg cap, Tolterodine 2mg tab, Atorvastatin 10mg tablet, Tizanidine 2mg tablet, and Divalproex two tabs, 125 mg tab. (5 missed) On 10/16/2021 at 5:00pm, the Protein Shake was not given, and the explanation was, "not available." (1 missed) On 10/23/2021 at 8:00am and at 5:00 pm. there were no staff's initials or refusals for the Protein Shake. (2 missed) On 10/29/2021 at 5:00pm there were not staff's initials and no refusals. (1 missed) A total of (6) prescribed medications were not administered and (4) Protein Shakes were not administered.

November 2021:
On 11/03/2021, Protein Shake, was not administered at 12:00pm. There was no refusal documented. (1missed)
On 11/05/2021, the Protein Shake was not administered at 12:00pm or an 5:00 PM. (2 missed).
On 11/09,10,11/2021 at 5:00pm there were no initials for the Protein shake and there were no documented refusals. (3 missed)
On 11/15,16/2021, at 5:0 pm there were no initials and no refusals. (2 missed)
On 11/22,23,24 and 25/2021, there were no initial or refusals for the 8:00 AM Protein Shakes. (4 missed)
On 11/22,23,24,25/21 for the 12:00pm there were no initials and no refusals. (4 missed)
On 11/22,23,24,2021 there were no initials for the 5:00pm and no refusals. (3 missed)
On 11/27/2021, at 12:00pm there were no initials or refusals. (1 missed)
On 11/27/2021, at 5:00pm there were no initials and no refusals. (2 missed)
On 11/28/2021, at 5:00pm there were no initials and no refusal. (1 missed)
This totals 23 Protein Shakes not administered in the month of November 2021.

December 2021: The MAR was only for 12/01-09/2021, at 8:00 AM's and there were no missing medications. There was one Protein Shake not administered on 12/03/2021 at 12:00 pm. There was no documented refusal by Resident A. A total of one (1) missed Protein Shake.

On 01/12/2021, I conducted a telephone exit conference with the Licensee Designee, Louis Andriotti Jr. and agreed with my findings.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being S333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	I reviewed Resident A's, MAR's from September 2021 through the first week of December 2021. In September/2021, I found nine prescribed medicines had not been administered and the Protein Shake was not given four times. For the month of October/2021, I found six prescribed medications were not administered and Protein Shakes were not administered. For the month of November 2021, I found 23 Protein Shakes were not administered for the month. For December 2021, 0ne Protein shake was not administered in the first nine days of the month. A total of 19 prescribed medications were not administrated and 31 Protein Shakes were not administered. During this investigation Ms. Slater, LPN, randomly choose three other resident's Resident B, Resident C and Resident D and we reviewed their MAR's, from September 2021, through the first week in December of 2021. We did not observe any prescribed medications that were missed on these three residents. During this investigation evidence was found that Resident A did not receive 19 prescribed medications and 31 of his prescribed dietary supplements, therefore a rule violation was found.
CONCLUSION:	**VIOLATION ESTABLISHED**

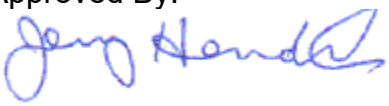
IV. RECOMMENDATION

I recommend that they provided an acceptable plan of correction and the status of the license remain the same.

01/12/2022

Arlene Smith, MSW — Date
Licensing Consultant

Approved By:



01/12/2022

Jerry Hendrick — Date
Area Manager