GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 4, 2022

Louis Andriotti, Jr.
Vista Springs Ctr/Memory Care & Rediscovery
3736 Vista Springs Ave.
Grand Rapids, MI 49525

RE: License #:	AH410400149
Investigation #:	2022A1021014
	Vista Springs Ctr/Memory Care & Rediscovery

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 authorized representative 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) 284-9730.

Sincerely,

Kimberly Horst, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH410400149
Investigation #:	2022A1021014
Complaint Receipt Date:	12/06/2021
Investigation Initiation Date:	12/07/2021
Report Due Date:	02/05/2022
Licensee Name:	Vista Springs Northview, LLC
Licensee Address:	Ste 110 2610 Horizon Dr. SE Grand Rapids, MI 49546
Licensee Telephone #:	(616) 364-4690
Administrator:	Jennifer Slater
Authorized Representative:	Louis Andriotti, Jr.,
Name of Facility:	Vista Springs Ctr/Memory Care & Rediscovery
Facility Address:	3736 Vista Springs Ave. Grand Rapids, MI 49525
Facility Telephone #:	(616) 364-4690
Original Issuance Date:	03/04/2020
License Status:	REGULAR
Effective Date:	09/04/2021
Expiration Date:	09/03/2022
Capacity:	56
Program Type:	ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident B's plan of care is not reflective of her needs.	Yes
Additional Findings	Yes

III. METHODOLOGY

12/06/2021	Special Investigation Intake 2022A1021014
12/07/2021	Special Investigation Initiated - Telephone interviewed complainant
12/07/2021	APS Referral referral sent to APS
12/29/2021	Inspection Completed On-site
01/04/2022	Exit Conference Exit conference with authorized representative Lou Andriotti

ALLEGATION:

Resident B's plan of care is not reflective of her needs.

INVESTIGATION:

On 12/6/21, the licensing department received a complaint with allegations Resident B does not receive appropriate care at the facility. The complainant alleged Resident B has been observed soaked in urine and feces and wearing dirty clothes.

On 12/7/21, the allegations in this report were sent to centralized intake at Adult Protective Services (APS).

On 12/7/21, I interviewed Carline Hospice care manager Stefanie Machiela by telephone. Ms. Machiela reported Resident B has been on service with Careline since October 2021. Ms. Machiela reported Resident P receives a nurse visit once a week and an aid visit twice a week at the facility. Ms. Machiela reported hospice workers have observed Resident B soaked in urine and feces. Ms. Machiela reported the feces have been dried and caked onto resident's body, indicating extended time between changes and assist with peri-care. Ms. Machiela reported

Resident B has been found heavily soiled multiple times at different times of the day when visits occurred and progressively in worse state at each visit.

On 12/29/21, I interviewed wellness director Stacy Rowe at the facility. Ms. Rowe reported Resident B was admitted on hospice services for additional services at the facility. Ms. Rowe reported Resident B has a diagnosis of dementia and is pleasantly confused. Ms. Rowe reported Resident B has Crohn's Disease and is incontinent of bowel. Ms. Rowe reported Resident B is unable to take herself to the bathroom and care staff are responsible for ensuring Resident B goes to the bathroom. Ms. Rowe reported Resident B should be on a check and change every two hours. Ms. Rowe reported Careline Hospice is to provide two showers a week, but the agency is short-staffed and therefore have not been providing showers. Ms. Rowe reported Careline Hospice has not provided the days they will be providing showers to Resident B. Ms. Rowe reported due to the lack of communication and coordination with Careline, caregivers are still providing Resident B showers. Ms. Rowe reported caregivers are to document in their system when they provide care and showers, but this does not always occur.

On 12/29/21, I interviewed caregiver Isabella Ciarrocchi at the facility. Ms. Ciarrocchi reported Resident B is incontinent and caregivers are to check and change Resident B every two hours. Ms. Ciarrocchi reported Careline Hospice is to provide showers and the facility does not provide showers. Ms. Ciarrocchi reported the facility provides laundry services. Ms. Ciarrocchi reported Resident B has lots of clothes and always has clean and appropriate clothing on.

On 12/29/21, I interviewed caregiver Aubrey Garcia at the facility. Ms. Garcia reported every morning Resident B has a bowel accident. Ms. Garcia reported at times Resident B has multiple accidents a day. Ms. Garcia reported when Resident B has an accident, she will clean Resident B and sometimes shower Resident B. Ms. Garcia reported Resident B lacks the cognitive ability to take herself to the bathroom. Ms. Garcia reported Resident B is on frequent checks. Ms. Garcia reported when she reports to work on first shift, Resident B has been found soaked in urine because third shift has not changed her appropriately.

On 12/29/21, I observed Resident B at the facility. Resident B was observed to be in her bed with clean clothes and clean linen. Resident B had a large selection of clean clothes in her room. Resident B reported she is happy to be living at the facility and has no concerns.

I reviewed Resident B's service plan. Resident B's service plan read,

> *"Toileting: Ext x1 for toileting tasks*
> *Frequent rounding: Staff to frequently round on community member throughout shift. This includes passing a snack or water, tidying up room, assisting to an activity, completing ADL's and when called as needed from*

call pendent. Wellness checks through night shift. Staff are to initial each shift that rounding was completed."

I reviewed December 2021 Task Administration Record (TAR) for Resident B. The TAR read,

"Toileting-extensive assist x1 check and change as needed."

The TAR revealed this task was to be completed every two hours throughout the day. This was not completed on multiple days and times.

"Bathing ext assist x1 for bathing tasks, also includes cleaning room changing bedding."

The TAR revealed Resident B received a shower on 12/7, 12/14, and 12/26.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.
ANALYSIS:	Interviews with caregivers at the facility revealed Resident B is to be checked and changed every two hours. This information was not appropriately described in her service plan as the service plan read Resident B was to be checked and changed as needed. In addition, review of Resident B's TAR revealed Resident B was not checked and changed as set forth in the TAR.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

While at the facility, I observed multiple caregivers not wearing masks.

I reviewed the MIOSHA Emergency Rules, Rule 6(4). The rule read,

"The employer shall require any employee, except fully vaccinated persons, to

wear face coverings when employees cannot consistently maintain 6 feet of separation from other individuals indoors in the workplace. However, fully vaccinated persons must continue to wear face coverings when in the healthcare setting where patients may be present and when using airplane or public transportation if required by the latest CDC guidance."

APPLICABLE RULE	
R 325.1917	**Compliance with other laws, codes, and ordinances.**
	(1) A home shall comply with all applicable laws and shall furnish such evidence as the director shall require to show compliance with all local laws, codes, and ordinances.
ANALYSIS:	Within the healthcare setting, such as home for the aged, masks are to be worn by all employees. The facility is not appropriately following these guidelines.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

Ms. Rowe reported Resident B is unable to use a call pendent for assistance, is to be checked and changed every two hours, is active with Careline Hospice, and does not use an assistive device for ambulation.

Review of Resident B's service plan read,

"Transferring: Supervision
Provide supervision and offer guidance/encouragement while transferring. Verify resident is using 4ww with all transfers."

Toileting: Ext x1 for toileting tasks
Frequent rounding: Staff to frequently round on community member throughout shift. This includes passing a snack or water, tidying up room, assisting to an activity, completing ADL's and when called as needed from call pendent. Wellness checks through night shift. Staff are to initial each shift that rounding was completed."

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(5) A home shall update each resident's service plan at least annually or if there is a significant change in the

	resident's care needs. Changes shall be communicated to the resident and his or her authorized representative, if any.
ANALYSIS:	Review of Resident B's service plan revealed the plan was not updated in accordance with her care needs. Resident P is to be a check and change every two hours, does not use a pendent, does not use a walker, and is active with Careline Hospice. This information was omitted from her service plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 1/4/21, I conducted an exit conference with authorized representative Lou Andriotti by telephone. Mr. Andriotti had no questions about the findings in this report.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the status of the license.

1/3/22

Kimberly Horst Date
Licensing Staff

Approved By:

01/03/2022

Andrea L. Moore, Manager Date
Long-Term-Care State Licensing Section