GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 19, 2021

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

RE: License #: AH410397992
Investigation #: 2022A1010011
Vista Springs Wyoming

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 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 (616) 356-0183.

Sincerely,

Lauren Wohlfert, Licensing Staff
Bureau of Community and Health Systems
350 Ottawa N.W. Unit 13, 7th Floor
Grand Rapids, MI 49503
(616) 260-7781
enclosure

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

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AH410397992 |
| | |
| **Investigation #:** | 2022A1010011 |
| | |
| **Complaint Receipt Date:** | 12/07/2021 |
| | |
| **Investigation Initiation Date:** | 12/08/2021 |
| | |
| **Report Due Date:** | 02/06/2022 |
| | |
| **Licensee Name:** | Vista Springs Wyoming LLC |
| | |
| **Licensee Address:** | Ste 110<br>2610 Horizon Dr. SE<br>Grand Rapids, MI 49546 |
| | |
| **Licensee Telephone #:** | (616) 259-8659 |
| | |
| **Administrator:** | Kathy Cooper |
| | |
| **Authorized Representative:** | Louis Andriotti, Jr. |
| | |
| **Name of Facility:** | Vista Springs Wyoming |
| | |
| **Facility Address:** | 2708 Meyer Ave SW<br>Wyoming, MI 49519 |
| | |
| **Facility Telephone #:** | (616) 288-0400 |
| | |
| **Original Issuance Date:** | 12/10/2019 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 06/10/2021 |
| | |
| **Expiration Date:** | 06/09/2022 |
| | |
| **Capacity:** | 147 |
| | |
| **Program Type:** | AGED<br>ALZHEIMERS |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Resident B was given a discharge notice due to an increase in her level of care. | No |
| Staff do not weigh Resident B monthly. | Yes |

## III. METHODOLOGY

| | |
|---|---|
| 12/07/2021 | Special Investigation Intake<br>2022A1010011 |
| 12/08/2021 | Special Investigation Initiated - Letter<br>APS referral emailed to Centralized Intake |
| 12/08/2021 | APS Referral<br>APS referral emailed to Centralized Intake |
| 12/16/2021 | Contact - Telephone call made<br>I interviewed the complainant by telephone |
| 12/16/2021 | Inspection Completed On-site |
| 12/16/2021 | Contact - Document Received<br>Received resident service plan, staff notes, discharge notice |
| 01/06/2022 | Contact – Document Received<br>Received the facility's resident Nutrition and Weight policy and procedure via email |
| 01/19/2022 | Exit Conference<br>Completed with licensee authorized representative Lou Andriotti |

**ALLEGATION:**

**Resident B was given a discharge notice due to an increase in her level of care.**

**INVESTIGATION:**

On 12/7/21, the Bureau received the complaint. The complaint read Resident B was "given the notice of discharged [sic] in October. The reason being they believe that

her care has increased since she was admitted May 20, 2021." The complaint also read, "[Resident B] went through a period of adjustments. There was some confusion and anxiety since moving to this new location. [Resident B] is now in better spirits then she was when she started. They believe now she is required [sic] more care. They disagree with the initial passement [sic] they did and that was just given to them when they were given this complaint. The assessment was not what it should have said compared to the assessment they did more recently."

On 12/16/21, I interviewed the complainant by telephone. The complaint reported the discharge notice Resident B received was not accurate. The complainant stated the facility maintained Resident B's care level has increased since she moved into the facility, however the assessment that was completed at the time of Resident B's admission was "not correct."

The complainant explained Resident B moved into the facility with her husband, Resident C. The complainant reported Resident C required more assistance with activities of daily living (ADLs) than Resident B. The complainant said this has not changed since they both moved into the facility. The complainant stated Resident B did have a "hard adjustment" when she moved into the facility, however she is well adjusted now. The complainant expressed concern that another move would cause Resident B confusion again and she will have a hard time adjusting to another new facility.

The complainant stated Resident B moved to Vista Springs Wyoming from a different assisted living facility. The complainant reported another move would likely negatively affect Resident B and Resident C due to it being their third move.

The complainant reported that although Resident B has adjusted to the facility, she continues to have behavioral issues. The complainant questioned whether Resident B had any current behavioral issues. The complainant stated the facility also identified Resident B required full assistance while eating, however the complainant questioned whether this was accurate.

On 12/16/21, I interviewed health and wellness director Mackenzie Ferguson at the facility. Ms. Ferguson reported Resident B was issued a 30-day discharge notice in October. Ms. Ferguson stated the facility has allowed Resident B to stay past the discharge date until a new placement is located.

Ms. Ferguson said Resident B's care needs have exceeded what the facility can provide. Ms. Ferguson reported the facility does not have enough staff to accommodate Resident B's care needs. Ms. Ferguson explained Resident B's level of care increased since she was admitted to the facility. Ms. Ferguson reported Resident B now requires assistance from two staff persons to transfer. Ms. Ferguson stated Resident B continuously tries to get up and transfer by herself and falls. Ms. Ferguson said Resident B also requires full assistance from staff to eat during meals.

Ms. Ferguson reported Resident B also has physical and verbal aggression towards staff during the provision of her care. Ms. Ferguson stated there were incidents when Resident B “swung” to hit staff. Ms. Ferguson said Resident B has wounds on her leg and receive wound care treatment from Kindred Hospice.

Ms. Ferguson provided me with a copy of Resident B’s service plan for my review. The *BATHING* section of the plan read, “Provide two person assistance with bathing/showering(dressing/undressing, washing body/hair, drying, getting safely in & out of shower/tub, ect.) Community member also uses a shower chair during bathing.” The *DRESSING* section read, “Provide one person assistance for upper body and 2 person assist with lower extremities with dressing/undressing and choosing proper attire.” The *EATING* section of the plan read, “Provide assistance with eating (cutting food, feeding, ect.). Requires staff assistance with eating meals and snacks.” The *MOBILITY* section of the plan read, “Provide one person assistance with mobility/ambulating. Community member uses a walker with gait belt for short ambulation’s and a wheelchair for longer ambulation’s. Member may Need 2 person assist if weak.”

Ms. Ferguson provided me with a copy of Resident B’s staff notes for my review. Notes dated 6/3 read Resident B was verbally and physically aggressive toward staff. A note dated 6/3 at 7:15 pm read, “Late Entry: - Yesterday (6/2/31), Community member was soak and wet [sic] in her chair after supper. I went there to toilet her, was very angry and refused my care. I asked help [sic] from C hall care giver to help her get changed. Community Member almost bit care giver’s hand and yelled so bad at her. She constantly refused our care but we all distracting her little by little were able to changed [sic] her brief and washed her up.”

A note dated 6/8 read, “CM was sent to Metro Health Hospital due to self harm to employees. Observation report is completed.” Notes dated 7/8, 7/9, 7/14, 7/18, 8/9, 8/21, 9/14, 10/7, and 11/1 read Resident B fell and was found on the floor by staff. Notes dated 10/11, 10/21, 10/24, 11/8, and 11/12 read Resident B was “screaming” continuously. A note dated 10/22 read, “Community Member was scheduled for shower tonight. She was very aggrebated [sic] and combating [sic] during the time of shower. She was screaming and asking ladies for help. Later, after shower, Erica came and help [sic] me transfer her to the chair. She almost hit on my chin with her fist, but luckily I moved my head away quickly. Later she was behaving ok.”

A note on 10/14 read, “Spoke with Ashley from Home Based Primary Care in regards to community member and the increased cares. Ashely agreed that community members cares have increased are extensive to total dependent on all ADL cares. Asked Ashley if she felt they were in the right facility. Ashely stated that she feels community members cares exceed what an assisted living facility can handle.”

Ms. Ferguson provided me with a copy of Resident B's signed admission contract. The *Vista Springs Wyoming Discharge Policy* section read, "Vista Springs' discharge policy is in accordance with Act 368, 1978 Public Health Code [MCL 333.20201 (3)(e)] and Home for the Aged Licensing rules and reflects that a resident can only be discharged for the following reasons.

1. Medical Reasons

   Person's requiring professional nursing care such as the kind normally provided in a nursing home shall not be admitted or retained unless the resident (Community Member) is enrolled in and receiving services from a licensed hospice program or a home health agency. Community Members whose care progresses to this level without hospice services will be given a 30-day discharge notice. This does not preclude the accommodation of a resident who becomes temporarily ill while in the home, but who does not require continuous nursing care. Community Members whose care needs are advanced beyond the scope of the home's abilities to provide appropriate care will receive a discharge notice.

2. His or Her welfare or the welfare of other residents

   Vista Springs may discharge a Community Member if the individual displays unacceptable sexual behavior, self-destructive behavior, or becomes harmful to themselves or others, or has demonstrated behaviors that pose a serious risk of harm to themselves or others that cannot be effectively managed in the community."

I observed the contract was signed by Resident B's responsible person, Relative B1.

Ms. Ferguson provided me with a copy of Resident B's discharge notice for my review. The notice was dated 10/18 and read, "This letter is to serve as a less than 30-day notice of discharge for [Resident B] due to the increased specific care needs for her. It is the policy of Vista Springs Wyoming & Rediscovery Lofts that if any person requiring continuous professional nursing care such as the kind normally provided in a nursing home should not be admitted or retained within the community. This does no preclude the accommodation of a resident who becomes temporarily ill while in the home, but who does require continuous nursing care.

Vista Springs has worked in cohesiveness with Spectrum Home Base Primary Care with medication adjustments to try and help with behaviors, such has not given any resolution to her overall safety. Vista Springs has also maintained communication with family, and put in place various safety measure for increased care needs. It is a recommendation of Spectrum Home Based Primary Care that [Resident B] be placed in 24- hour nursing care community.

If you have any digression in this matter, you or any other Designated Representative may reach out to Department of Human Services Home for the Aged and file a complaint with our Licensure.

Vista Springs will make every effort to help find alternate placement to assist the family. The State Licensing consultant for our Home for the Aged License has been notified of this less than 30-day notice as part of our responsibility of our Licensure. If you have any further questions, please contact Mackenzie Ferguson and/or Kathy Cooper at Vista Springs Wyoming."

On 12/16/21, I interviewed medication technician (med tech) Tina Fuentes at the facility. Ms. Fuentes' statements regarding resident B's care needs were consistent with Ms. Ferguson and Resident B's service plan.

| **APPLICABLE RULE** | |
|---|---|
| **R 325.1922** | **Admission and retention of residents.** |
| | **(15) A home may discharge a resident before the 30-day notice if the home has determined and documented that either, or both, of the following exist:**<br>**(a) Substantial risk to the resident due to the inability of the home to meet the resident's needs or due to the inability of the home to assure the safety and well-being of the resident, other residents, visitors, or staff of the home.**<br>**(b) A substantial risk or an occurrence of the destruction of property.** |
| **ANALYSIS:** | The interviews with Ms. Ferguson, Ms. Fuentes, along with review of Resident B's staff notes and discharge notice revealed her care needs exceed what staff at the facility can provide. Resident B exhibits verbal and physical aggression that places staff at risk. Resident B also often attempts to transfer herself without staff assistance, putting her own safety at risk. As a result, the facility identified staff are unable to meet Resident B's care needs consistent with their program statement. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

**ALLEGATION:**

**Staff do not weigh Resident B monthly.**

**INVESTIGATION:**

On 12/16/21, the complainant reported staff at the facility do no weigh Resident B monthly. The complainant stated Resident B has lost 30 pounds since she was admitted in May. The complainant reported at the time of Resident B's admission, staff stated Resident B's weight and vitals would be taken each month. The complainant expressed concern Resident B's weight has not been taken monthly.

On 12/16/21, Ms. Ferguson said it was the facility's policy and procedure to take and document a resident's weight each month. Ms. Ferguson reported to her knowledge, staff have taken and documented Resident B's weight since she was admitted.

Ms. Ferguson reported staff were unable to obtain Resident B's weight for the month of December because when they entered the room to obtain it, Resident B's family and hospice staff were present. Ms. Ferguson stated the family requested hospice staff take and document Resident B's weight.

On 12/16/21, Ms. Fuentes' statements regarding Resident B's weight and the facility's month weight policy and procedure were consistent with Ms. Ferguson. Ms. Fuentes reported she was trained to take and document resident's weight monthly.

On 1/6/22, I received a copy of Resident B's *Vital History for [Resident B]* via email for my review. The document read Resident B's weight was taken on 5/20/21. There were no additional months when Resident B's weight was documented.

I also received a copy of the facility's *Nutrition and Weights* policy and procedure for my review. The *PURPOSE* section of the policy read, "The community monitors weights and provides diets as ordered by the physician." The *PROCEDURE* section of the policy read, "1. The Health and Wellness Director assigns the task of measuring Community Measure weights to caregivers on admission and monthly, unless otherwise ordered by physician. *Note – Refer to POLICY and Routine Monitoring for Vital Signs and Weights VS – 103.* 2. A weight change of five pounds or 5% of body weight in a 30-day period shall be reported to the Health and Wellness Director and attending physician. 3. Nutritional supplements will be offered to the Community Member if ordered by the physician. 4. Modified diets will be provided as ordered by the physician."

| **APPLICABLE RULE** | |
|---|---|
| **R 325 1921** | **Governing bodies, administrators, and supervisors.** |
| | **(1) The owner, operator, and governing body of a home shall do all of the following:** |

| | |
|---|---|
| | **(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.** |
| **ANALYSIS:** | The interviews with Ms. Ferguson and Ms. Fuentes, along with review of the facility's *Nutrition and Weights* policy and procedure revealed a resident's monthly weight is to be obtained so it can be monitored by staff. Review of Resident B's *Vital History* document revealed her weight for the month of May was documented. No other monthly weights were documented, therefore her weight history while she resided at the facility is unknown. This is not consistent with an organized program to provide protection. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

I shared the findings of this report with licensee authorized representative Lou Andriotti by telephone on 1/19. Mr. Andriotti reported staff will be re-educated on the facility's *Nutrition and Weights* policy and procedure.

## IV. RECOMMENDATION

I recommend the status of the license remain unchanged.

1/7/22

Lauren Wohlfert Date
Licensing Staff

Approved By:

01/18/2022

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