GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 1, 2022

Louis Andriotti Jr.
IP Vista Springs Trillium Village OpCo
Suite 110
2610 Horizon Dr. SE
Grand Rapids, MI 49546

RE: License #: AH630401935
Investigation #: 2022A1027080
Vista Springs Trillium Village Estate

Dear Mr. Andriotti:

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 by the authorized representative and dated.

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 (517) 241-1970.

Sincerely,

Jessica Rogers

Jessica Rogers, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 285-7433
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630401935
Investigation #:	2022A1027080
Complaint Receipt Date:	07/27/2022
Investigation Initiation Date:	07/28/2022
Report Due Date:	09/26/2022
Licensee Name:	IP Vista Springs Trillium Village OpCo
Licensee Address:	Suite 110 2610 Horizon Dr. SE Grand Rapids, MI 49546
Licensee Telephone #:	(616) 259-8659
Administrator:	Stanley Davey
Authorized Representative:	Louis Andriotti Jr.
Name of Facility:	Vista Springs Trillium Village Estate
Facility Address:	6800 Trillium Dr Clarkston, MI 48346
Facility Telephone #:	(248) 878-5266
Original Issuance Date:	01/21/2020
License Status:	REGULAR
Effective Date:	07/21/2022
Expiration Date:	07/20/2023
Capacity:	99
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A did not receive her medication as prescribed.	Yes
Resident A had an untreated wound.	No
Additional Findings	No

III. METHODOLOGY

07/27/2022	Special Investigation Intake 2022A1027080
07/28/2022	Special Investigation Initiated - Letter Email sent to complainant requesting additional information
07/28/2022	Contact - Document Received Email received from complainant with requested information and documentation
08/15/2022	Contact - Document Sent Email sent to administrator Ms. Savich to request documentation pertaining to investigation for Resident A.
08/16/2022	Contact - Document Received Fax received from the facility with requested documentation
08/17/2022	Contact - Document Received Email received from AR Louis Andriotti to setup the telephone conference call
08/17/2022	Contact - Telephone call made Telephone conference call and interview conducted with Louis Andriotti, Owner and Authorized Representative, Suzi Savich LPN, Senior Managing Partner/Authorized Representative, Trillium Village Estate, Bowe Davey, Managing Partner, Trillium Village Estate, Liz Coffelt, Senior Operations Support Executive/Operations Development, Shannon Snapp, Health & Wellness Officer, Trillium Village, Jennifer Slater, Quality Assurance Nurse Executive, Vista Springs, Margaret Chamberlain, Attorney At Law, Rolf Law
08/17/2022	Contact - Document Received

	Email received from Mr. Davey with incident report for Resident A
08/25/2022	Contact - Document Sent Email sent to administrators Ms. Savich and Mr. Davey requested documentation requested during conference call
08/31/2022	Contact - Document Sent Email sent to administrators Ms. Savich and Mr. Davey requested documentation requested during conference call
09/01/2022	Contact - Document Received Email received from Mr. Andriotti with requested documentation
09/01/2022	Inspection Completed-BCAL Sub. Compliance
09/27/2022	Exit Conference Conducted by telephone with authorized representative Mr. Andriotti and Mr. Davey

ALLEGATION:

Resident A did not receive her medication as prescribed.

INVESTIGATION:

On 7/27/2022, the department received a complaint through the online complaint system which read Resident A had not received her Rivastigmine patch daily as ordered since October 2021. The complaint read Clarkston Pharmacy was contacted to check refill dates for the Rivastigmine in which a quantity of 30 patches were filled on 10/20/2021, 12/06/2021, and 2/15/2022. The complaint read on 4/26/2022, there were 8 Rivastigmine patches on the facility's medication cart. The complaint read there should have been 187 Rivastigmine patches from 10/20/2021- 4/26/2022 applied to Resident A in which 97 doses of meds were missed.

On 7/28/2022, the department requested additional information from the complainant as well as the pharmacy invoices.

On 8/17/2022, I conducted a telephone call with administrators Susan Savich and Bowe Davey, licensee authorized representative Lou Andriotti, health and wellness officer Shannon Snapp, quality assurance nurse Jennifer Slater, and attorney Margaret Chamberlain. Ms. Snapp stated Resident A's Rivastigmine (Exelon) patches were supplied by the pharmacy in box with quantity of 30. Ms. Snapp stated she assumed the patches were delivered automatically to the facility monthly. Ms. Snapp stated once she investigated the administration of the Resident A's patches in April 2022, she reached out to the pharmacist who informed her that the refills

were not automatic and needed to be re-ordered monthly. Ms. Snapp stated she completed an incident report in April 2022 in which was submitted to the department reporting the medication error for Resident A, as well as her physician. Mr. Andriotti stated it was recognized the facility had medication errors in which there was a quality assurance initiative, one of which to include medication passes beginning August 24, 2022.

I reviewed Resident A's service plan which read she required staff to manage and administer her medications.

I reviewed Resident A's medication administration records (MAR) dated 10/1/2021 through 4/25/2022 which read staff initialed Rivastigmine 4.6 mg/24 hr patch as applied to the resident.

I reviewed incident report dated 4/26/2022 for Resident A which read Resident A's Durable Power of Attorney (DPOA) inquired when the Exelon (Rivastigmine) patches were last filled. The report read staff observed the medication box which was dated 2/22 with 6 patches left. The report read Dr. Rojas was notified and he discontinued the patch. The report read corrective measures to prevent recurrence were that all oral medications were filled on a month cycle and staff were not aware that the patches come only as ordered. The corrective measures read Ms. Snapp spoke with the pharmacist and in the future, he will send them on a month cycle.

I reviewed Resident A's chart notes dated 4/26/2022 which read consistent with the incident report.

Review of the Clarkston Pharmacy invoices read consistent with the complaint. The invoices read the date filled for each dose of Rivastigmine 4.6 MG/24HR patch and the cost. The invoices read Rivastigmine was filled and billed to Resident A on 8/2/2021, 9/8/2021, 10/20/2021,12/6/2021, and 2/15/2022. The invoices for November 2021, January and March 2022 did not read the medication was refilled or billed to Resident A. The invoices lacked the quantity refilled each month.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(1) Medication shall be given, taken, or applied pursuant to labeling instructions or orders by the prescribing licensed health care professional.

ANALYSIS:	Review of facility documentation revealed the facility was responsible for Resident A's medication management and administration. Review of Resident A's MARs read staff documented the Rivastigmine patches were applied however there was lack of sufficient supply to apply them daily as prescribed by the physician as evidence by the resident's billed invoices and the facility's incident report. Although the medication errors were reported to Resident A's physician and the department, facility staff lacked implementation of appropriate corrective action measures to educate facility medication technicians who documented the patch was applied to Resident A without sufficient supply.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A had an untreated wound.

INVESTIGATION:

On 7/27/2022, the department received a complaint through the online complaint system which read Resident A moved from the facility on 7/12/20222 in which a pressure ulcer was identified on her foot and had not been reported nor treated.

On 8/17/2022, I conducted a telephone call with call with administrators Susan Savich and Bowe Davey, licensee authorized representative Lou Andriotti, health and wellness officer Shannon Snapp, quality assurance nurse Jennifer Slater, and attorney Margaret Chamberlain. Ms. Savich stated in June 2022 it was brought to Ms. Snapp's attention Resident A's legs were swollen and they had contacted her physician. Ms. Savich stated Resident A was evaluated by her nurse practitioner on 6/16/2022 in which she was started on Lasix for congestive heart failure. Ms. Savich stated Resident A utilized a wheelchair, so her legs dangled however staff elevated them while in bed to reduce the swelling and to try to prevent skin breakdown. Ms. Savich stated staff provided Resident A's showers in which there was a "stop and watch" form staff were to complete and turn into nursing management when there were concerns identified during showers. Ms. Snapp stated Resident A was at risk to develop open areas on her legs and feet due to the swelling, however staff had not identified any areas. Ms. Snapp stated Resident A had been evaluated by the podiatrist in July 2022, prior to her leaving the facility, in which there were concerns identified.

I reviewed Resident A's service plan which read staff were to aid with grooming and Resident A required total care.

I reviewed Resident A's June and July 2022 chart notes which read consistent with staff interviews. Note dated 6/16/2022 read the nurse practitioner assessed Resident A and ordered lab work. Note dated 6/30/2022 read the nurse practitioner assessed Resident A, started Lasix daily and ordered a cardiology consultation. Note dated 7/5/2022 read podiatrist Dr. Schons visited Resident A and there were no new orders.

Per email correspondence with Mr. Andriotti on 9/1/2022, staff had not completed a "stop and watch" form for resident.

I reviewed Resident A's care logs from 7/5/2022 through 7/12/2022 which read consistent with her service plan. The logs read staff assistance with Resident A's dressing daily.

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:	Review of Resident A's service revealed she required two person assist with transfers and total assistance for grooming which read consistent with the July 2022 care logs. Review of the facility chart notes revealed Resident A was evaluated by a nurse practitioner and podiatrist in June and July 2022, consecutively in which there was no identification of an untreated wound. Staff documentation read consistent with Resident A's service plan and based on this information, there was insufficient evidence to substantiate this allegation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 9/27/2022, I shared the findings of this report with authorized representative Mr. Andriotti and administrator Mr. Davey by telephone.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

09/01/2022

Jessica Rogers Date
Licensing Staff

Approved By:

09/27/2022

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