GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 19, 2022

Louis Andriotti, Jr.
IP Vista Springs Timber Ridge Opco, LLC
2610 Horizon Dr. SE
Grand Rapids, MI 49546

RE: License #: AH190401909
Investigation #: 2023A1021019
Vista Springs Imperial Park at Timber Ridge

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 #:	AH190401909
Investigation #:	2023A1021019
Complaint Receipt Date:	12/05/2022
Investigation Initiation Date:	12/05/2022
Report Due Date:	02/04/2023
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/ Authorized Representative:	Louis Andriotti, Jr.
Name of Facility:	Vista Springs Imperial Park at Timber Ridge
Facility Address:	16260 Park Lake Road East Lansing, MI 48823
Facility Telephone #:	(517) 339-2322
Original Issuance Date:	11/04/2020
License Status:	REGULAR
Effective Date:	05/04/2022
Expiration Date:	05/03/2023
Capacity:	40
Program Type:	AGED

II. ALLEGATIONS

	Violation Established?
Resident A was not administered medications.	Yes
Additional Findings	No

III. METHODOLOGY

12/05/2022	Special Investigation Intake 2023A1021019
12/05/2022	Special Investigation Initiated - Letter requested resident's documents
12/07/2022	Contact - Document Sent received resident documents
12/08/2022	Contact-telephone call made Interviewed corporate compliance director Tina Brindley
12/19/2022	Exit Conference Exit conference with authorized representative Louis Andriotti, Jr.

ALLEGATION:

Resident A was not administered medications.

INVESTIGATION:

On 12/5/22, licensing staff received an incident report that read,

> *"facility was unable to give multiple medications due to lack of valid prescriptions for Ibuprofen 200mg tablet, Alprazolam 0.25mg, and Gabapentin 100MG capsule. We contacted the pharmacy and were told that these medications did not have any refills left. Throughout the week of not having these medications we tried to inform DPOA but could not reach DPOA. Physician that the facility had on file to contact for medication orders was not up to date provider. Once the staff was able to get ahold of (DPOA) she informed us that the physician was not accurate and informed us of the provider to contact. Resident did have other medications to control his pain (Norco) if needed while his medications were not available. He did not complain of any pain, however outward signs of pain such as grimaces and sounds were noticed when getting him in/out of bed and during other mobility."*

On 12/8/22, I interviewed corporate compliance officer Tina Brindley by telephone. Ms. Brindley reported Resident A admitted to the facility from a subacute rehabilitation facility. Ms. Brindley reported when Resident A admitted to the facility the medications were provided by HomeTown Pharmacy. Ms. Brindley reported the prescriptions needed to be refilled but there were no refills available. Ms. Brindley reported the facility reached out to Relative A1 and Relative A1 reached out to the physician with no response. Ms. Brindley reported the facility also reached out to the physician with a delayed response. Ms. Brindley reported Relative A1 expressed wanting to switch physicians to the facility physician. Ms. Brindley reported for this switch to take place, paperwork needs to be signed. Ms. Brindley reported the facility thought the paperwork needed to be signed by Relative A1 even though Resident A does not have an activated durable power of attorney for healthcare. Ms. Brindley reported the facility finally was able to reach the physician, receive refill order, and administer the medications to Resident A. Ms. Brindley reported Resident A is now active with the facility physician. Ms. Brindley reported Resident A had no major signs of pain with missing these medications.

I reviewed observation notes for Resident A. The notes read,

> *"11/23: Monday during the day we informed (DPOA) that we were out of (Resident A's) medications. She was very willing to help and contacted the heart to heart on call nurse to get these medications over. The nurse stated that she would get these orders and it would be here no later than yesterday evening. We just contacted pharmacy to see where the medications are at, since we never received. Hometown pharmacy said they are checking on it and will have it sent over. Will update once we have confirmation these were sent or that they were delivered.*
> *11/23: (Resident A) medications are still running low. Still do not have a correct doctor to get these scripts. I have called the doctor that we have on file and he does not see this one anymore. (DPOA) has been contacted and the pharmacy needs new scripts to send orders. Will update when we have one.*
> *11/27: (DPOA) has given proper doctor office to contact for medication refills. I have updated the contact in his file.*
> *11/27: Just completed the D/C in ECP for (Resident A) Norco as the doctors request for this was sent to use by HomeTown Pharmacy.*
> *11/28: been having a hard time getting (Resident A) medications refilled. Now that we have his current PCP/office to contact, I have contacted them and they have sent his Alprazolam, Gabapentin, and Ibuprofen to hometown pharmacy. Please update observation when these medications come in.*
> *11/28: got ahold of someone from Sparrow Internal Medicine Residency, they are faxing (Resident A) orders for his supplemental continuous oxygen, as well as the Bipap that he wears nightly.*
> *11/29: spoke to nurse manager at Sparrow Internal Medicine Residency, she will be sending orders for (Resident A) O2 and bipap machine. She was paging the*

physician to get his scripts signed for Xanax, gabapentin, ibuprofen and Norco. Will update when we receive them- (DPOA) has been notified."

I reviewed Resident A's medication administration record (MAR) for November 2022. The MAR revealed Resident A was prescribed the following medications:

Ibuprofen 200mg tablet: take 1 tablet by mouth three times daily (pain)
Gabapentin 100mg tablet: take 2 capsules by mouth three times daily (neuropathy)
Alprazolam 0.25mg tablet: take one tablet by mouth 2x daily

The MAR revealed Resident A did not receive the following medications on the following days:

Ibuprofen 200mg tablet: 11/14-11/30
Alprazolam 0.25mg tablet: 11/14, 11/23-11/30
Gabapentin 100mg tablet: 11/14, 11/19-11/30

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.**
For Reference: R 325.1901	**Definitions.**
	(16) "Protection" means the continual responsibility of the home to take reasonable action to ensure the health, safety, and well-being of a resident as indicated in the resident's service plan, including protection from physical harm, humiliation, intimidation, and social, moral, financial, and personal exploitation while on the premises, while under the supervision of the home or an agent or employee of the home, or when the resident's service plan states that the resident needs continuous supervision.
ANALYSIS:	Resident A was not administered Ibuprofen, Alprazolam, and Gabapentin for multiple days due to no refills on the medications. The facility lacked an organized program of protection for Resident A as evidenced by the facility did not

	have an active physician for Resident A, did not reach the physician in a timely manner, and did not have Resident A sign paperwork to become active with the in-house physician.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 12/19/22, I conducted an exit conference with authorized representative Louis Andriotti, Jr. by telephone.

IV. RECOMMENDATION

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

Kimberly Horst 12/8/22

Kimberly Horst Date
Licensing Staff

Approved By:

Andrea Moore 12/16/2022

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