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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 8, 2023

Louis Andriotti, Jr.
Vista Springs Riverside Gardens LLC
2610 Horizon Dr. SE
Grand Rapids, MI 49546

RE: License #: AH410397993
Investigation #: 2023A1021017
Vista Springs Riverside Gardens

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 #:	AH410397993
Investigation #:	2023A1021017
Complaint Receipt Date:	12/01/2022
Investigation Initiation Date:	12/02/2022
Report Due Date:	2/01/2023
Licensee Name:	Vista Springs Riverside Gardens LLC
Licensee Address:	Ste 110 2610 Horizon Dr. SE Grand Rapids, MI 49546
Licensee Telephone #:	(616) 259-8659
Administrator/ Authorized Representative:	Louis Andriotti, Jr.
Name of Facility:	Vista Springs Riverside Gardens
Facility Address:	2420 Coit Ave. NE Grand Rapids, MI 49505
Facility Telephone #:	(616) 365-5564
Original Issuance Date:	07/22/2020
License Status:	REGULAR
Effective Date:	01/22/2022
Expiration Date:	01/21/2023
Capacity:	70
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Facility did not respond appropriately to Resident A's needs.	Yes
Additional Findings	No

III. METHODOLOGY

12/01/2022	Special Investigation Intake 2023A1021017
12/02/2022	Special Investigation Initiated - Telephone interviewed complainant
12/05/2022	Contact-Telephone call made Interviewed Joy DeVires managing partner
12/07/2022	Contact - Document Received received resident documents
12/08/2022	Contact-telephone call made Interviewed SP1
12/08/2022	Contact-Telephone call made Interviewed SP2
12/13/2022	Contact-telephone call made Interviewed SP3
12/14/2022	Contact-Telephone call made Interviewed SP4
12/16/2022	Contact-Telephone call made Interviewed SP5
12/16/2022	Contact-Telephone call made Interviewed SP6
12/22/2022	Exit Conference Exit conference with authorized representative Louis Andriotti, Jr.
01/05/2023	Contact-Telephone call made

	Received additional information from administrator
01/09/2023	Contact-Document Received Received timeline of events
01/11/2023	Contact-Documents Received Received facility policy
02/08/2023	Exit Conference

ALLEGATION:

Facility did not respond appropriately to Resident A's needs.

INVESTIGATION:

On 12/1/22, the licensing department received a complaint with allegations Resident A was neglected at the facility.

On 12/02/22, I interviewed the complainant by telephone. The complainant alleged Resident A was transferred to the hospital due to difficulty breathing. The complainant alleged Resident A was diagnosed with pneumonia and was septic. The complainant alleged at the hospital Resident A started the process to sign onto hospice services with Faith Hospice. The complainant alleged Resident A was transferred back to the facility on 11/17/22 in the evening hours. The complainant alleged she observed Resident A at the facility on 11/18/22. The complainant alleged Resident A was not moved from her bed the entire night. The complainant alleged Resident A still had hospital sheets covering her, her brief was so statured it was falling apart, and Resident A was very ill. The complainant alleged the facility reported staff were afraid to touch her and did not provide any attention to Resident A. The complainant alleged Resident A was not provided any comfort medications or oxygen. The complainant alleged Resident A was on oxygen and Morphine in the hospital. The complainant alleged Resident A passed away later that day. The complainant alleged Resident A was severely neglected leading up to her passing away.

On 12/5/22, I interviewed facility managing partner Joy DeVries by telephone. Ms. DeVries reported Resident A was transferred to the hospital and then was re-admitted to the facility. Ms. DeVries reported Resident A had started the hospice enrollment process in the hospital. Ms. DeVries reported Resident A readmitted to the facility on 11/17 around 9:00pm. Ms. DeVries reported Faith Hospice came the following morning to enroll Resident A in hospice service and Resident A passed away a few hours later.

On 12/8/2022, I interviewed staff person 2 (SP2) by telephone. SP2 reported she was working the evening Resident A returned to the facility from the hospital. SP2 reported Resident A had expressed she did not want to pass away at the hospital, so the facility advocated for Resident A to return to the facility. SP2 reported when Resident A admitted to the facility, she did not have any supplemental oxygen. SP2 reported per EMS, Resident A did not transfer in the ambulance with any supplemental oxygen. SP2 reported the facility had some oxygen from a previous need and oxygen was placed on her. SP2 reported the facility offered food but she declined. SP2 reported Resident A had a Fentanyl patch on her from the hospital. SP2 reported the facility try to make Resident A as comfortable as possible. SP2 reported caregivers transferred Resident A from the ambulance gurney and placed her in her bed. SP2 reported caregivers covered Resident A with her own blankets. SP2 reported caregivers wanted to make Resident A as comfortable as possible and did not change her clothes or sheets. SP2 reported Resident A was not soiled and was comfortable. SP2 reported many caregivers were very close with Resident A and were visibly upset that Resident A was close to end of life. SP2 reported caregiver stayed in Resident A's room until she fell asleep.

On 12/16/22, I interviewed SP6 by telephone. SP6 reported she worked the evening Resident A admitted back to the facility. SP6 reported Resident A's sheets were changed but she was not changed out of the hospital gown due to verbalizing pain and discomfort. SP6 reported Resident A did not come with oxygen but that oxygen was placed on Resident A. SP6 reported Resident A had a Fentanyl patch placed by the hospital, unsure when, and the caregivers did not administer any additional pain medication. SP6 reported she does not recall if Resident A had a fever.

On 12/13/22, I interviewed SP3 by telephone. SP3 reported she worked the shift prior to Resident A's passing. SP3 reported she changed Resident A's depend on a few times. SP3 reported caregivers checked on Resident A every few hours throughout the night. SP3 reported Resident A did grimace in pain a few times and additional pillows were placed underneath her.

On 12/14/22, I interviewed SP4 by telephone. SP4 reported he changed Resident A's depend once in the evening of 11/17. SP4 reported he did not provide any other care to Resident A.

On 12/16/22, I interviewed SP5 by telephone. SP5 reported she worked the morning when Resident A passed away. SP5 reported she did not hear of caregivers refusing to provide care to Resident A. SP5 reported Resident A received appropriate care.

On 12/8/22, I interviewed SP1 by telephone. SP1 reported the morning Resident A passed she was passing medications in the morning and was called to the resident's room by the hospice company around 9:00am. SP1 reported at that time Resident A had a temperature of 101.7. SP1 reported Resident A's brief was wet but it was unclear if it was wet due to urine or sweat. SP1 reported Resident A's sheets were damp and the sheets were from the hospital or the ambulance. SP1 reported a dose

of Morphine was administered to Resident A. SP1 reported Resident A had a pain patch on her. SP1 reported no pain medications were administered to Resident A prior to the administration of the Morphine. SP1 reported she was told that when staff members would move Resident A, the resident would moan in pain.

On 01/05/2023, I interviewed HomeTown Pharmacy manager Jason Hendges by telephone. Mr. Hendges reported the prescriptions from the hospital was received to his pharmacy at 2:30pm on 11/17/2022. Mr. Hendges reported prescriptions are typically delivered to the facility around 11:00pm. Mr. Hendges reported the facility can request a stat delivery and the medications can be delivered within one or two hours. Mr. Hendges reported there was no communication from the facility that the medications were to be delivered on a stat order.

I reviewed Resident A's medication administration record (MAR). The MAR revealed Resident A was prescribed Morphine 100mg/5 mL solution with instructions to take 0.25ml by mouth every two hours as needed x3 days. Resident A was also prescribed Acetaminophen 650mg suppository with instruction to administer one suppository rectally every six hours as needed for pain/fever. The MAR revealed these medications were not administered on 11/17 or 11/18.

I reviewed HomeTown Pharmacy delivery sheets dated 11/17/22 1717. The sheet revealed the pharmacy delivered Fentanyl patch and Morphine 100mg/5mL solution.

I reviewed hospital discharge instructions for Resident A. The instructions revealed Resident A was discharged with new medication for Fentanyl patch and Morphine concentrated solution.

I reviewed facility policy titled *Temporary Relocation/Absences*. The policy read,

> *"Follow appropriate procedures when Community Member are temporarily absent from the Community to ensure the continuity of Community Member services.*
> *3. When a Community Member returns to the Community after a temporary stay in another community, discharge orders must be received from the community before services may be provided.*
> *4. Revise the Community Member's Service Plan if significant changes in his/her service needs/preferences have occurred during his/her absence.*
> *5. If the Community is managing the Community Member's medications, incorporate any medication and/or treatment order changes, as reflected on the Community Member's discharge orders, on the Community Member's medication record. Complete a new medication sheet(s) for the Community Member if significant changes in medication or treatment orders have occurred."*

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

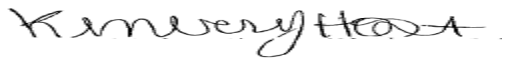
"11/18: went in about 9:15am determined that (Resident A) was not going to be able to take meds. About 9:45am NP Jill from Faith Hospice arrived to do her face to face. At this time she had me give PRN dose of Morphine 0.25m due to her respirations being 40 per minute, and she was also given her scheduled Fentanyl patch. About 10:15am her breathing was down to 1 minute then nothing. During this whole time I tried to reach Jen White as she does not have a current DNR on file and we needed order to give another dose of morphine. I spoke as well to Missy Worpel her court guardian, she stated verbally to myself and Joy that she did not want CPR. She passed and we did call 911per policy, they then have us start CPR anyways until the Fire Dept arrived and took over. She was pronounced at 11am.

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 re-admitted to the facility late in the evening on 11/17/22 with new orders for pain medication. The facility did not receive the medications until hours after Resident A re-admitted and no contact with the pharmacy was made to expediate the receiving of the medications. Once the medications were received, they were not administered to Resident A even with her signs of pain, moaning, facial grimaces, and shortness of breath. The facility failed an organized program of protection to ensure Resident A was provided appropriate level of care.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 02/08/2023, 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.



1/17/2023

Kimberly Horst — Date
Licensing Staff

Approved By:

02/06/2023

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