GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 30, 2023

Louis Andriotti, Jr.
IP Vista Springs Timber Ridge Opco, LLC
Ste 110
2610 Horizon Dr. SE
Grand Rapids, MI 49546

RE: License #: AL190383347
Investigation #: 2023A0783010
Vista Springs Terraces 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 was required. On 3/20/2023, you submitted an acceptable written corrective action plan.

It is expected that the corrective action plan be implemented within the specified time frames as outlined in the approved plan.

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,

Ondrea Johnson

Ondrea Johnson, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 256-2181

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL190383347
Investigation #:	2023A0783010
Complaint Receipt Date:	12/22/2022
Investigation Initiation Date:	12/22/2022
Report Due Date:	02/20/2023
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:	Louis Andriotti, Jr.
Licensee Designee:	Louis Andriotti, Jr.
Name of Facility:	Vista Springs Terraces at Timber Ridge
Facility Address:	16260 Park Lake Road East Lansing, MI 48823
Facility Telephone #:	(517) 339-2322
Original Issuance Date:	11/14/2016
License Status:	REGULAR
Effective Date:	05/14/2021
Expiration Date:	05/13/2023
Capacity:	20
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A did not receive his Paxlovid medication as prescribed.	Yes

III. METHODOLOGY

12/22/2022	Special Investigation Intake 2023A0783010
12/22/2022	Special Investigation Initiated – Telephone call with facility wellness coordinator Taylor McGrath
01/12/2023	Inspection Completed On-site with direct care staff member Taylor McGrath
03/02/2023	Contact - Document Received-Resident A's MAR
03/10/2023	Contact - Telephone call made with licensee designee Lou Andriotti
03/10/2023	Exit Conference with Lou Andriotti
03/10/2023	Inspection Completed-BCAL Sub. Compliance
03/10/2023	Corrective Action Plan Requested and Due on 03/25/2023
03/20/2023	Corrective Action Received
03/20/2023	Corrective Acton Plan Approved

ALLEGATION:

Resident A did not receive his Paxlovid medication as prescribed.

INVESTIGATION:

On 12/22/2022, this complaint was received through the Bureau of Community and Health Systems (BCHS) online complaint system. This complaint alleged Resident A did not receive his prescribed Paxlovid medication as prescribed.

On 12/22/2022, AFC Licensing Consultant Leslie Herrguth conducted an interview with direct care staff member Taylor McGrath whose role is wellness coordinator. Ms. McGrath confirmed that a medication error occurred regarding Resident A which was discovered by staff member Kaylee Becker. The medication Paxlovid was temporarily prescribed to Resident A due to COVID-19 and has been discontinued.

On 1/12/2023, AFC Licensing Consultant Leslie Herrguth conducted an onsite investigation at the facility with direct care staff member Taylor McGrath. Ms. McGrath stated the medication technician contacted her and informed her that staff failed to administer Resident A's medication Paxlovid as instructed by the physician and accidentally missed giving Resident A this medication. Ms. McGrath stated Resident A's primary physician was notified and provided instructions for staff to follow.

On 3/2/2023, I reviewed Resident A's *Medication Administration Record* (MAR) for the month of December 20222. According to this MAR, Resident A was prescribed to take Paxlovid CO-PACK (EUA) oral by mouth with a start date of 11/30/2022 to 12/6/2022. According to this MAR, Resident A was not administered this medication on 12/5/2022 and 12/6/2022.

On 3/10/2023, I conducted an interview with licensee designee Lou Andriotti who stated that he was also made aware of this medication error by staff members and this issue has been addressed with all staff members and medication retraining will be provided.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based on my investigation which included interviews with direct care staff member Taylor McGrath, licensee designee Lou Andriotti and review of Resident A's MAR there is evidence Resident A was not given his medication Paxlovid as prescribed. Ms. McGrath stated staff members accidentally missed administering Resident A his medication Paxlovid and notified Resident A's primary physician who provided instructions for staff members to follow. According to Resident A's MAR Resident A was prescribed to take Paxlovid CO-PACK (EUA) oral by mouth with a start date of 11/30/2022 to 12/6/2022. Resident A was not administered Paxlovid on 12/5/2022 and 12/6/2026 therefore medication was not given as prescribed.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 3/10/2023, I conducted an exit conference with licensee designee Lou Andriotti. I informed Mr. Andriotti of my findings and allowed him an opportunity to ask questions and make comments.

On 3/20/2023, I received and approved an acceptable corrective action plan.

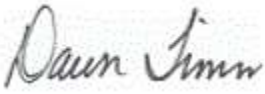
IV. RECOMMENDATION

An acceptable corrective action plan was approved therefore I recommend the current license status remain unchanged.

3/23/2023

Ondrea Johnson — Date
Licensing Consultant

Approved By:



03/30/2023

Dawn N. Timm — Date
Area Manager