GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

July 31, 2023

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

RE: License #: AH630401935
Investigation #: 2023A0784064
Vista Springs Trillium Village Estate

Dear Louis 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 responsible party and a date.

Please review the enclosed documentation for accuracy and contact me with any questions. If I am not available, and you need to speak to someone immediately, please contact the local office at (517) 284-9730.

Sincerely,

Aaron L Clum

Aaron Clum, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 230-2778

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630401935
Investigation #:	2023A0784064
Complaint Receipt Date:	05/25/2023
Investigation Initiation Date:	05/26/2023
Report Due Date:	07/24/2023
Licensee Name:	IP Vista Springs Trillium Village OpCo
Licensee Address:	2610 Horizon Dr. SE Suite 110 Grand Rapids, MI 49546
Licensee Telephone #:	(616) 259-8659
Administrator:	Jennifer Bishop
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:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Lack of staff training	Yes
Inadequate care was provided to Resident A	Yes
Additional Findings	Yes

III. METHODOLOGY

05/25/2023	Special Investigation Intake 2023A0784064
05/26/2023	Inspection Completed On-site
05/26/2023	Special Investigation Initiated - On Site
06/29/2023	Contact - Document Sent Request for additional documentation sent via email to administrator Jenny Bishop and AR Lou Andriotti Jr.
06/30/2023	Contact - Document Received Requested documents received from Ms. Bishop via email
07/31/2023	Exit - Email Report sent to Jennifer Bishop and Lou Andriotti Jr.

ALLEGATION:

Lack of staff training

INVESTIGATION:

On 5/25/2023, the department received this online complaint.

According to the complaint, Associates, specifically Associate 1 and Associate 2, have transferred Resident A with a Hoyer lift but have not been trained on how to use it.

On 5/26/2023, I interviewed wellness director Jinne Wiggle at the facility. Ms. Wiggle stated Resident A was no longer at the facility as he had passed away in April 2023. Ms. Wiggle stated Resident A lived at the facility from the end of February 2023 until

his passing. Ms. Wiggle stated Resident A was a person who required two staff and a Hoyer lift for transfers. Ms. Wiggle stated Hoyer transfers require at least two staff and that staff are supposed to be trained on proper Hoyer transfers prior to conducting such a transfer. Ms. Wiggle stated she completed a Hoyer transfer one time for Resident A, with other staff present, to demonstrate the proper way to do so. Ms. Wiggle stated she was not formally trained by the facility on how to conduct Hoyer transfers. Ms. Wiggle stated she was uncertain if Associate's 1 and 2 had been provided formal Hoyer lift training. Ms. Wiggle stated that as care staff, Associates 1 and 2 are expected to perform any kind of transfer required by a resident.

On 5/26/2023, I interviewed Associate 2 at the facility. Associate 2 stated she has been working with the facility since sometime in October 2022. Associate 2 stated she had been trained on how to properly conduct a Hoyer lift in the job she had prior to working with the facility but had not been formally trained by this facility. Associate 2 stated that when she was hired work with the facility, she was never required to provide any proof, either by demonstration or documentation, that she had been trained on how to use a Hoyer lift. Associate 2 stated she has conducted Hoyer transfer for Resident A and is aware that Associate 1 has also.

I reviewed Associate 1's training *ORIENTATION CHECKLIST*, provided by Ms. Wiggle. The checklist included sections titled *SKILL* under which several sub-sections were included, which indicated which skills Associate 1 had been trained on for her job. Under sub-section *Transfers/Position/AMB*, several types of transfers were listed including "1 Person Assist, 2 Person Assist, Gait Belt, Hoyer, Sit to Stand Lift, Turning". Next to each of these skills there was a section for "DATE COMPLETED", "TRAINER INITIALS" and "EMPLOYEE INITIALS" to denote that training has been provided. Review of Associate 1's training document revealed no date for completion and no corresponding initials from a trainer or from Associate 1 next to the sections for "Hoyer lift" or "Sit to Stand Lift". Ms. Wiggle was unable to locate training documentation for Associate 2.

I reviewed Resident A's Resident Information sheet which confirmed Resident A was admitted to the facility on 2/27/2023 and discharged on 4/15/2023.

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 complaint alleged Resident A was a person who required a Hoyer Lift for transfers and that Associates 1 and 2 would conduct such transfers for Resident A without having been properly trained. The investigation revealed that not only had Associates 1 and 2 not been properly, but the wellness director, Ms. Wiggle, had also done so while not having been formally trained by the facility to demonstrate to other staff how to conduct the transfer.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Inadequate care was provided to Resident A

INVESTIGATION:

According to the complaint, Resident A was not bathed or provided oral care as specified in Resident A's service plan.

When interviewed, Ms. Wiggle stated she was not aware of any concerns with Resident A's bathing or oral care. Ms. Wiggle stated Resident A did require assistance from staff, per his service plan, with bathing and oral care. Ms. Wiggle stated the facility maintains activities of daily living tracking for residents on a *TASK ADMINISTRATION RECORD* done within the facilities computer data system. Ms. Wiggle stated that for each scheduled task, when assistance is provided, staff input their initials into the system for the day and time of assistance provided which correlates to the scheduled task as dictated by the resident service plan.

I reviewed Resident A's Service Plan. Under a section titled *BATHING-TOTAL ASSISTANCE*, the plan indicated Resident A was to be bathed "Weekly [Mon] @ 8:00AM, As Needed". Under a section titled *ORAL CARE-ASSISTANCE*, the plan indicated Resident A required "Total assistance Daily@ Wake up, Bedtime".

I reviewed Resident A's March and April 2023 *TASK ADMINISTRATION RECORD*, provided by administrator Jennifer Bishop. In review of the March record, under a section titled *BATHING-TOTAL ASSISTANCE*, there were no staff initials for 3/06/2023 and 3/13/2023 to indicate that Resident A had been offered an opportunity for bathing. Under a section titled *ORAL CARE-ASSISTANCE*, sub-titled *Wake Up*, no staff initials were entered for 3/11/2023, 3/12/2023, 3/25/2023, 3/26/2023 and 3/31/2023. Under the corresponding ORAL CARE-ASSISTANCE sub section Bedtime, no staff initials were entered for 3/11/2023, 3/12/2023, 3/14/2023, 3/23/2023, 3/24/2023, 3/25/2023, 3/26/2023, 4/01/2023 and 4/02/2023.

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.
For Reference: R 325.1933	**Personal care of residents.**
	(2) A home shall afford a resident the opportunity and instructions when necessary for daily bathing, oral and personal hygiene, daily shaving, and hand washing before meals. A home shall ensure that a resident bathes at least weekly and more often if necessary.
ANALYSIS:	The complaint alleged Resident A did not received bathing and oral care according to his service plan. Review of ADL tracking documentation for Resident revealed several dates which staff did not mark the record to indicate Resident A was assisted with bathing or oral care as dictated by his service plan. Additionally, while the service plan indicated Resident A is supposed to receive a shower once a week “as needed”, licensing rules require that at bathing be provided, or at least offered, once a week and not on an “as needed” basis.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

During the onsite, Ms. Wiggle was unable to locate and provide her training documentation upon request. Upon request, Ms. Wiggle provided employee files for Associate 1 and 2, however Associate 1’s file did not include any training documentation. Ms. Wiggle stated the file should have included the training documentation.

APPLICABLE RULE	
R 325.1944	**Employee records and work schedules.**
	(1) A home shall maintain a record for each employee which shall include all the following: **(d) Summary of experience, education, and training.**

ANALYSIS:	Upon request, Ms. Wiggle was unable to provide training documentation for herself or Associate 1. Based on the findings the facility is not in compliance with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, it is recommended that the status of the license remain unchanged.

Aaron L Clum 7/05/2023

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Aaron Clum Date
Licensing Staff

Approved By:

Andrea L Moore 07/28/2023

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