GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

November 7, 2023

Louis Andriotti, Jr.
Vista Springs Wyoming LLC
2610 Horizon Dr. SE Ste 110
Grand Rapids, MI 49546

RE: License #: AH410397992
Investigation #: 2024A1010002
Vista Springs Wyoming

Dear Licensee:

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) 241-1970.

Sincerely,

Lauren Wohlfert, Licensing Staff
Bureau of Community and Health Systems
350 Ottawa NW Unit 13, 7th Floor
Grand Rapids, MI 49503
(616) 260-7781
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH410397992
Investigation #:	2024A1010002
Complaint Receipt Date:	10/02/2023
Investigation Initiation Date:	10/06/2023
Report Due Date:	12/01/2023
Licensee Name:	Vista Springs Wyoming LLC
Licensee Address:	Ste 110 2610 Horizon Dr. SE Grand Rapids, MI 49546
Licensee Telephone #:	(616) 259-8659
Administrator:	Jessica Hunter
Authorized Representative:	Louis Andriotti
Name of Facility:	Vista Springs Wyoming
Facility Address:	2708 Meyer Ave SW Wyoming, MI 49519
Facility Telephone #:	(616) 288-0400
Original Issuance Date:	12/10/2019
License Status:	REGULAR
Effective Date:	06/10/2023
Expiration Date:	06/09/2024
Capacity:	147
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A's blood was drawn by an outside agency without an order to do so.	Yes

III. METHODOLOGY

10/02/2023	Special Investigation Intake 2024A1010002
10/06/2023	Special Investigation Initiated - Letter APS referral emailed to Centralized Intake
10/06/2023	APS Referral APS referral emailed to Centralized Intake
10/06/2023	Contact - Telephone call made Attempted to interview the complainant by telephone, there was a prompt stating the mailbox was full. I was unable to leave a telephone message
10/09/2023	Inspection Completed On-site
10/09/2023	Contact - Document Received Received resident observation notes and visitor sign in information for 5/15/23
10/31/2023	Contact – Telephone call made Interviewed SP1 by telephone
10/31/2023	Contact – Telephone call made Interviewed W1 by telephone
11/07/2023	Exit Conference

ALLEGATION:

Resident A's blood was drawn by an outside agency without an order to do so.

INVESTIGATION:

On 10/2/23, the Bureau received the allegations from the online complaint system. The complaint read, “Unauthorized blood draw that TOOK PLACE in the dining room, right after Lunch between 12:30 and 1:30 PM. Women [sic] not wearing scrubs or a uniform but I was told was wearing a name tag drew [Resident A’s] blood.” The complaint also read Resident A’s physician did not order the blood draw.

On 10/6/23, I emailed an Adult Protective Services (APS) referral to Centralized Intake.

On 10/6/23, I attempted to interview the complainant by telephone, there was a prompt stating the mailbox was full. I was unable to leave a telephone message or request a telephone call back.

On 10/9/23, I interviewed managing partner Magdalen Heerspink at the facility. Ms. Heerspink reported the facility’s senior operations support executive Jessica Hunter was the administrator at the time of the incident on 5/15/23. Ms. Heerspink reported Ms. Hunter investigated the incident and found there was no order for a blood draw for Resident A. Ms. Heerspink said Ms. Hunter would have more information as she contacted the lab staff person who was in the facility on 5/15/23 and investigated the incident.

On 10/9/23, I interviewed Ms. Hunter by telephone. Ms. Hunter stated Relative A1 informed her that Resident A received an unauthorized blood draw on 5/15/23. Ms. Hunter reported Relative A1 discovered Resident A had an unauthorized blood draw because she observed Resident A had a cotton ball taped to her arm.

Ms. Hunter reported she contacted resident A’s physician after she spoke with Relative A1. Ms. Hunter stated resident A’s physician’s office confirmed they did not order a blood draw for Resident A. Ms. Hunter said she then reviewed the visitor information for those who checked into the facility on 5/15/23 and found Witness 1 (W1) who works with a contracted lab company, entered the facility around lunch time.

Ms. Hunter stated she spoke with W1 by telephone. Ms. Hunter reported W1 denied performing an unauthorized blood draw on Resident A. Ms. Hunter said W1 would not admit to mistakenly doing a blood draw on Resident A without a physician’s order. Ms. Hunter stated W1 likely did not admit to drawing Resident A’s blood out of fear of getting in trouble. Ms. Hunter reported W1 is a phlebotomist.

Ms. Hunter provided me with a copy of her *Observation* notes for Resident A via email for my review. A note dated 5/18/23 read, “Talked with [Relative A1] as CM had a mystery lab drawn on Monday. Talked with Dr. Bates’ office and they did not ask for nor perform a blood draw for CM. Called American Health Association who typically draws labs for Vista Springs on Tuesdays. Our Lab book did not show a lab drawn on Monday nor did we have a CM with a draw in RL. American Health Association is reviewing their logs to ensure nothing was drawn for [Resident A].

Talked with staff member who did see the draw occur. Will continue reviewing data to determine what may have occurred." A note dated 5/26/23 read, "Checked lab results from American Health Associates and also with Home MD's lab company and none have results for member's lab draws. Still looking into labs to see who could've drawn labs on her."

On 10/9/23, I observed Resident A in the secured memory care unit of the facility. I was unable to engage Resident A in meaningful conversation.

Ms. Hunter provided me with the facility's *Visitor Log* document for 5/15/23. The log read W1 entered the facility at 12:28 pm and exited at 4:11 pm. The *Visitor Type* section of the log read, "Blood Service." The *Company Name* section of the log read, "Great Lakes Medical Laboratory Inc (GLML) - Farmington Hills." The *Reason for Visit* section of the log listed Resident B's name. Ms. Hunter wrote in her email, "I believe [W1] was working for Total Labs but USED to work for Great Lakes and never changed over her company name in that system (it auto-populates).

On 10/31/2023, I interviewed Staff Person 1 (SP1) by telephone. SP1 stated she observed Resident A having her blood drawn in the dining room around lunch time on 5/15/23. SP1 said she recalled thinking it was unusual that a resident was having blood drawn in a common area where others could observe. SP1 reported residents are usually brought to a private area or their rooms to have their blood drawn by lab staff. SP1 reported although she thought it was unusual that Resident A had her blood drawn in the dining room, she did not say anything to the lab staff person during the incident.

SP1 stated she did not know the name of the lab staff person, or the name of the lab the staff person was worked for when Resident A's blood was drawn. SP1 reported lab staff usually verify a resident's identity before they draw the resident's blood. SP1 said she did not know whether the lab staff person followed this process before drawing Resident A's blood on 5/15/23.

On 10/31/23, I interviewed W1 by telephone. W1 stated she did not complete a lab blood draw for Resident A on 5/15/23. W1 reported she is employed by Total Lab Solutions. W1 said she receives physician orders for the residents who she draws blood for before she completes the draw. W1 reported she did not receive a physician order to draw Resident A's blood, therefore she did not complete a draw for her. W1 reported she does not know who Resident A is and would be unable to identify her.

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 interviews with Ms. Heerspink, Ms. Hunter, SP1, along with my review of Resident A's observation notes, revealed Resident A had her blood drawn on 5/15/23 without a physician's order. Staff did not verify Resident A had a physician order for her blood to be drawn on 5/15/23. This is not consistent with an organized program of protection. Resident A's blood was also drawn in the dining room in the facility's secured memory care unit where others were able to observe.
CONCLUSION:	**VIOLATION ESTABLISHED**

I shared the findings of this report with licensee authorized representative Lou Andriotti on 11/7/23.

IV. RECOMMENDATION

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

10/31/2023

Lauren Wohlfert — Date
Licensing Staff

Approved By:

11/01/2023

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