GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

December 12, 2023

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

RE: License #: AH410397993
Investigation #: 2024A1028019
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 responsible party 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 I am not available, and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

Julie Viviano, Licensing Staff
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

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

I. IDENTIFYING INFORMATION

License #:	AH410397993
Investigation #:	2024A1028019
Complaint Receipt Date:	11/29/2023
Investigation Initiation Date:	11/30/2023
Report Due Date:	01/29/2024
Licensee Name:	Vista Springs Riverside Gardens LLC
Licensee Address:	Ste 110 2610 Horizon Dr. SE Grand Rapids, MI 49546
Licensee Telephone #:	(616) 259-8659
Authorized Representative/Administrator:	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:	01/22/2023
Expiration Date:	01/21/2024
Capacity:	70
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
The facility is not providing care in accordance with resident service plans.	Yes
The facility is short staffed.	No
Medications are administered by staff members with no training.	No
Additional Findings	Yes

III. METHODOLOGY

11/29/2023	Special Investigation Intake 2024A1028019
11/30/2023	Special Investigation Initiated - Letter
11/30/2023	APS Referral APS referral made to Centralized Intake.
12/06/2023	Contact - Face to Face Interviewed Employee A at the facility.
12/06/2023	Contact - Face to Face Interviewed Employee B at the facility.
12/06/2023	Contact - Document Received Received limited record and documentation from Employee A.
12/06/2023	Inspection Completed On-site Completed on-site inspection due to special investigation.

ALLEGATION:

The facility is not providing care in accordance with resident service plans.

INVESTIGATION:

On 11/29/2023, the Bureau received the allegations anonymously through the online complaint system.

On 11/20/2023, a referral was made to Adult Protective Services (APS) through Centralized Intake.

On 12/6/2023, I interviewed Employee A at the facility who reported no resident is left to sit in feces or urine by any shift. Employee A reported no knowledge of any care staff member or shift reporting that residents are being found at the beginning of shifts left sitting in urine or feces. Employee A reported no knowledge of any residents, resident's families, or staff reporting any complaints about care. Employee A reported staff complete rounds every two hours to ensure appropriate assistance to toilet and for safety. Employee A reported no knowledge of any resident who requires a two-person assist receiving only a one-person assist. There are six residents in the facility who currently receive two-person assistance, and all receive assistance from two staff members. Employee A reported the use of a Hoyer lift, sit to stand device, or a physical two-person transfer are always completed by two staff members. Employee A reported any resident who requires feeding assistance is provided assist and/or set-up per the service plan. Employee A reported no knowledge of any resident not receiving appropriate feeding assistance. Employee A provided me Resident A's, Resident B's, Resident C's, and Resident D's service plans for my review.

On 12/6/2023, I interviewed Employee B at the facility who reported no knowledge of any resident being left to sit in urine or feces. Employee B reported that would not be tolerated at the facility. Employee B reported no knowledge of any care staff members reporting that residents were not attended to or assisted appropriately on any shift. Employee B reported two person assists for any resident is completed by two staff members to include the use of Hoyer lift, sit to stand device, and physical assist. Employee B reported no knowledge of only one staff member completing a two person assist. Employee B also reported no knowledge of any resident not receiving appropriate feeding assistance from staff members.

On 12/6/2023, I interviewed Resident A who reported care staff check on [them] "about every two hours" and assist with toileting as needed. Resident A reported no knowledge of any residents being left to sit in urine or feces. Resident A reported if that happened, we all would know it and they [staff] try to stay on top of that so we don't have to wait too long". Resident A reported care staff assist residents who need help eating. Resident A also confirmed [they] receive two-person assist using a Hoyer lift with all transfers.

On 12/6/2023, I completed an onsite inspection due to this special investigation. During the inspection, a significant odor of urine was detected around resident room nine and into the adjacent common area and connecting hallway.

On 12/6/2023, After the on-site inspection, I interviewed Employee A again to inquire about the significant urine smell near and around resident room nine. Employee A reported Resident B who resides in room nine began demonstrating behaviors in

October 2023 by urinating in places other than the bathroom. Resident B was assessed for urinary tract infections and other conditions by the physician to determine the cause. Resident B was also seen by the neurologist and new medication was prescribed, which resulted in a decrease in behaviors but not the elimination of the behaviors. Resident B's floors, chair, bed, and couch have been affected by the urination and the facility residential service team has cleaned, sanitized, used urine eliminator, odor eliminator, steam cleaned, and incorporated air fresheners as well, but the smell persists. Housekeeping is completing room checks three times a day and facility staff are providing two-hour checks for toileting as well. However, Employee A reported Resident B is considered independent in the service plan with toileting because Resident A has the capabilities to use the restroom without assistance. Employee A reported Resident B's family is aware of the situation and Resident B is currently waiting for placement at a skilled facility. The room carpet will be replaced once Resident B exits the facility.

On 12/6/2023, I reviewed Resident A's service plan which revealed Resident A receives two-person using a Hoyer lift.

I reviewed Resident C's service plan which revealed Resident C receives two-person assist from facility staff for all transfers.

I reviewed Resident D's service plan which revealed Resident D receives two-person assist from facility staff using a sit to stand device.

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.

ANALYSIS:	It was alleged the facility does not follow residents service plans and residents are left to sit in urine and feces; residents are not assisted with feeding; and assigned two-person assists are completed with only one staff member. Interviews, on-site investigation, and review of documentation reveal the following: • There is no evidence to support residents do not receive feeding assistance. • There is no evidence to support two-person transfers are performed by one person. • There was no evidence to support residents are being left to sit in feces. However, onsite investigation, interviews, and review of documentation revealed Resident B urinates in places other than the bathroom within [their] room resulting in a significant urine odor in the room, adjacent common area, and hallway. Care staff, management, housekeeping staff, and Resident B's family are aware of this behavior. Resident B's floors, chair, bed, and couch have been affected by the urination and is need of removal and replacement due to the consistent urination. Resident B's consistent urination in [their] room is unsanitary and could result in a fall with potential injury as well. Also, Resident B's service plan states [they] are independent with toileting but Resident B's consistent daily urination in places other than the bathroom toilet conflicts with the level provision of independent in the service plan. Resident B should not be considered independent with toileting if Resident B is urinating daily in places other than the bathroom toilet. The facility does not have appropriate service plan provisions in place for supervision of Resident B; to keep Resident B's person and room sanitary and clean; to keep Resident B safe while toileting; and to prevent exposure of the significant urine odor to other residents at the facility and visitors that enter the facility. Therefore, the facility is in violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The facility is short staffed.

INVESTIGATION:

On 12/6/2023, Employee A reported the facility is not short staffed and four new staff members were recently hired. Employee A reported there are five to eight staff members on duty. [Is this on first shift?] Second shift has five to six staff members on duty and third shift has four to five staff members on duty. There are 46 residents total in the facility. Employee A reported the facility is overstaffed. I requested the working staff schedules from October 2023 to December 2023, but the facility was unable to provide due to having no access to the prior scheduling system since new management onboarded in November 2023.

On 12/6/2023, Employee B's statement is consistent with Employee A's statement.

On 12/6/2023, Resident A reported the facility "does not seem to be short staffed but they can be a little slow sometimes, but it is not that bad because I know they are helping others too."

On 12/6/2023, I completed an on-site inspection of the facility and observed an appropriate number of care staff on duty to assist residents.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(5) The home shall have adequate and sufficient staff on duty at all times who are awake, fully dressed, and capable of providing for resident needs consistent with the resident service plans.
ANALYSIS:	It was alleged the facility is short staffed. Interviews and on-site investigation reveal there is no evidence to support this allegation. An appropriate number of care staff were observed on duty during the on-site investigation. No violation found.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Medications are administered by staff members with no training.

INVESTIGATION:

On 12/6/2023, Employee A reported all staff members are trained to provide care, but not all staff members are trained to administer medications. Employee A reported there are some staff members that have expressed interest in administering medications, but they do not demonstrate the appropriate skill level to do so, so they are not allowed to administer medications. Employee A reported all staff members trained as medication technicians receive initial training and education. They also

receive continued education and training throughout the year as well Employee A provided me staff training documentation for my review.

On 12/6/2023, Employee B's statement was consistent with Employee A's statement.

On 12/6/2023, I reviewed the staff training documentation for the medication technicians on duty during my on-site investigation.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(6) The home shall establish and implement a staff training program based on the home's program statement, the residents service plans, and the needs of employees, such as any of the following: **(g) Medication administration, if applicable.**
ANALYSIS:	It was alleged medications are administered by untrained staff members. Interviews, on-site investigation, and review of documentation reveal staff members who administer medications are assessed and trained appropriately. No violation found.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

Additional Findings:

INVESTIGATION:

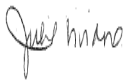
On 12/6/2023, when I requested the working staff schedules from October 2023 to December 2023, the facility could not provide them because facility staff have no access to the prior scheduling system since new management onboarded in November 2023.

APPLICABLE RULE	
R 325.1944	**Employee records and work schedules.**
	(3) The home shall retain the work schedules for the preceding 3 months.

ANALYSIS:	The facility did not retain the work schedules for the preceding 3 months.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an approved corrective action plan, I recommend the status of this license remain the same.



12/12/2023

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Julie Viviano Date
Licensing Staff

Approved By:

01/22/2024

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