STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

MARLON I. BROWN, DPA
DIRECTOR

April 24th, 2024

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

RE: License #: AH410397993
Investigation #: 2024A1021045
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 #:	2024A1021045
Complaint Receipt Date:	03/20/2024
Investigation Initiation Date:	03/20/2024
Report Due Date:	05/19/2024
Licensee Name:	Vista Springs Riverside Gardens LLC
Licensee Address:	Ste 110 2610 Horizon Dr. SE Grand Rapids, MI 49546
Licensee Telephone #:	(616) 259-8659
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
Status:	REGULAR
Effective Date:	02/09/2024
Expiration Date:	07/31/2024
Capacity:	70
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Incorrect medications administered.	Yes
Medications are left in residents' room.	Yes
Additional Findings	No

III. METHODOLOGY

03/20/2024	Special Investigation Intake 2024A1021045
03/20/2024	Special Investigation Initiated - Telephone interviewed Palliative Care
03/25/2024	Inspection Completed On-site
04/04/2024	Contact-Telephone call made University of Michigan Health Campus Dr. Walchak
04/24/2024	Exit Conference

ALLEGATION:

Incorrect medications administered.

INVESTIGATION:

On 03/20/2024, the licensing department received a complaint with allegations Resident A received incorrect medications. The complainant alleged Resident A received incorrect Warfarin dose as evidenced by his INR level being critically high at 9.3 level. The complainant also alleged Resident A received new medication orders for pain medication on 03/14/2024 and the revised orders were not changed as of 03/16/2024.

On 04/04/2024, I interviewed University of Michigan Health Campus Dr. Walchak office. The office reported Resident A was prescribed warfarin 5mg on December 14th, 2023, and then was changed to 2.5mg in January 2024. The office reported there was miscommunication between the office and the facility on who would be responsible for INR lab draws. The office reported they assumed the facility could complete the lab draws. The office reported in January it was found INR draws were not completed.

On 03/20/2024, I interviewed Trillium Palliative physician office. They reported the office changed Resident A's pain medications on 03/14/2024. The office reported they had a difficult time faxing the orders to the facility and the orders were not faxed until 03/15/2024 and the office reported they received notification the orders were successfully faxed to the facility. The office reported Resident A's dose of escitalopram was increased from 5 mg to 10 mg, dose of acetaminophen was changed from 500mg to 1 gram, and oxycodone was increased 2.5mg to 5.0mg.

On 03/25/2024, I interviewed facility administrator Joy Devries-Burns at the facility. Ms. Devries-Burns reported on 03/14/2024, Resident A's family came to the facility with after visit paperwork from Trillium Palliative. Ms. Devries-Burns reported she explained before implementing the changes, she would need the exact orders for the medication changes and the medications. Ms. Devries-Burns reported she spoke with the office on 03/15/2024 and the office explained they would be faxing the orders. Ms. Devries-Burns reported the facility received the orders on 2:18pm on 03/15/2024. Ms. Devries-Burns reported she then sent the orders to the pharmacy, Hometown Pharmacy. Ms. Devries-Burns reported she requested clarification from the pharmacy on the oxycodone medication as Resident A was changed from a liquid form to a pill form and the instructions were to use the pills and then switch to liquid form. Ms. Devries-Burns reported on 03/15/2024 at 4:58pm she received the orders from HomeTown Pharmacy. Ms. Devries-Burns reported the medications were delivered to the facility between 9:00-11:00pm on 03/15/2024. Ms. Devries-Burns reported the medication changes were narcotic medications. Ms. Devries-Burns reported only a few employees can check in narcotic medications and put them on the paper MAR. Ms. Devries-Burns reported the medications were checked in on 03/16/2024 around 2:00pm and Resident A received medication changes from then on. Ms. Devries-Burns reported she is very cautious on narcotic medications and the facility requires additional internal checks on implementing narcotics. Ms. Devries-Burns reported the medication changes were not stat orders nor were antibiotic orders and therefore it can take a few days for the changes to be implemented.

Ms. Devries-Burns reported it was communicated to Resident A's family at time of admission that INR lab draws could not be completed at the facility. Ms. Devries-Burns reported she spoke with the physician office that the facility did not have the "kit" to do labs, and this would need to be arranged between the office and Resident A. Ms. Devries-Burns reported the family was taking Resident A out for lab draws and the facility followed the appropriate dosing as the facility received the orders and implemented the appropriate dosing changes.

I reviewed Resident A's MAR for December 2023 and January 2024. The MAR revealed in December and January 2023, Resident A was prescribed Warfarin 5mg at 5:00pm. The MAR revealed care staff did not initial this was administered on 12/19, 12/20, 12/22, 12/23, 12/26, and 12/31. The January 2024 MAR revealed Resident A was prescribed Warfarin 2.5mg at bedtime with instruction to cut the 5mg

tablet in 1/2. The MAR revealed care staff did not initial this was administered on 1/19 and 1/25. The February MAR revealed it was handwritten for Warfarin 5mg and the medication was discontinued on 02/01 but was administer 02/01-02/03.

I reviewed Resident A's MAR for March 2023. The MAR revealed Resident A was prescribed:

Acetaminophen 500mg with instruction to take one tablet by mouth every six hours. It was handwritten this order was changed but did not have a discharge date. This medication was administered 03/01-03/18.

Oxycodone 5mg tablet with instruction to administer one tablet every 6 hours. This medication was started on 03/16 and was administered on 03/18.

Escitalopram 5mg with instruction to take one tablet by mouth once daily with a discharge date of 03/16 and order to increase dosage to 10mg. This medication was administered 03/01-03/09, 03/10-03/25.

Oxycodone 5mg tablet with instruction to administer one tablet every six hours with a start date of 03/16. The first time this medication was administered was on 03/18.

Acetaminophen 500mg with instruction to take two tablets by mouth every eight hours (three times a day) with a start date of 03/16. This medication was first administered on 03/19. This medication was only administered at most twice a day from 03/19-03/25.

Acetaminophen 500mg with instruction to administer one tablet by mouth every six hours. It was handwritten this medication had discharge/change. This medication was administered at 8:00am 03/01-03/09; 03/11-03/24, 2:00pm at 03/01-03/09; 03/12-03/17; 8:00pm at 03/01-03/02; 03/07-03/09, 03/13-03/14, 03/16, 3/21, and at 2:00am at 03/02-03/06; 03/09-03/14, 03/17-03/18.

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.**

	(p) "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	Review of Resident A's MAR and interviews conducted revealed Resident A had medication changes on 03/14/2024. The facility received the medications and orders late on the evening of 03/15/2024. However, Resident A did not receive the new medication orders until late in the day on 03/16/2024 due to their internal policy of verifying narcotic medications. Due to the facility lack of organized program, residents are at a risk of harm due to the delay in administering new medication orders.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to labeling instructions or orders by the prescribing licensed health care professional.
ANALYSIS:	Review of Resident A's MAR for March 2024 revealed Resident A had medication changes on 03/16/2024, however, Resident A continued to receive discontinued medications. In addition, Resident A was prescribed Warfarin 2.5mg in January 2024 and the medication was discontinued on 02/01/2024. Review of Resident A's MAR revealed 5mg Warfarin was administered on 02/01-02/03.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(3) Staff who supervise the administration of medication for residents who do not self-administer shall comply with all of the following: **(b) Complete an individual medication log that contains all of the following information:** **(v) The initials of the individual who administered the prescribed medication.**
ANALYSIS:	Resident A was prescribed Warfarin 2.5mg in December and January 2024. Review of Resident A MARs revealed multiple instances in which the staff member did not initial the log that the medication was administered. Similar findings were noted with Oxycodone 5mg.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Medications are left in residents' rooms.

INVESTIGATION:

The complainant alleged a pill cup with medications in the cup were found in Resident A's room. The complainant alleged mediation technician did not watch fully watch Resident B took a medication.

Ms. Devries-Burns reported the allegation regarding Resident B was investigated. Ms. Devries-Burns reported the medication technician administered medications to Resident B and left the room to administer medications to Resident B. Ms. Devries-Burns reported the medication technician reported the medications were successfully administered and no medications were left in the room. Ms. Devries-Burns reported the medication technicians are not to leave medications in residents' rooms.

Resident A reported medications have been left by facility staff in his room. Resident A reported it has only occurred a few times.

On 03/25/2024, I interviewed Resident C at the facility. Resident C reported medications have been left in on her table for her to take.

On 03/25/2024, I interviewed Resident D at the facility. Resident D reported the care

staff are sometimes busy and will leave a medication in his room. Resident D reported it is not a common occurrence, but it has occurred.

SP1 reported medications are not to be left in a resident's room. SP1 reported she has not witnessed this occurring.

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.**
	(p) "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:	Interviews conducted and review of documentation revealed the facility does not take reasonable precautions to ensure that prescription medication is not used by a person other than the resident for whom the medication is prescribed. This is evidenced by: Leaving medications in a resident's room does not constitute taking reasonable precautions to assure that the medication is not used by a person other than the resident for whom the medication is prescribed. **REPEAT VIOLATION:** **AH410397993_SIR_2023A102147 dated 04/20/2023** **CAP dated 05/05/2023**
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the status of the license.

04/08/2024

Kimberly Horst — Date
Licensing Staff

Approved By:

04/23/2024

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