GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 8, 2024

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

RE: License #: AH630401935
Investigation #: 2024A0585044
Vista Springs Trillium Village Estate

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 that I am not available, and you need to speak to someone immediately, please contact the local office at (517) 284-9730.

Sincerely,

Brender L. Howard

Brender Howard, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street, P.O. Box 30664
Lansing, MI 48909
(313) 268-1788
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630401935
Investigation #:	2024A0585044
Complaint Receipt Date:	04/16/2024
Investigation Initiation Date:	04/16/2024
Report Due Date:	06/16/2024
Licensee Name:	IP Vista Springs Trillium Village OpCo
Licensee Address:	Suite 110 2610 Horizon Dr. SE 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:	07/21/2023
Expiration Date:	07/20/2024
Capacity:	99
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was found unattended numerous times and there have been numerous times when resident must wait for long periods of time after pushing the pendant for help.	Yes
Toilet was stopped up.	No
Additional Findings	Yes

III. METHODOLOGY

04/16/2024	Special Investigation Intake 2024A0585044
04/16/2024	Special Investigation Initiated - Letter Referral emailed to Adult Protective Services (APS).
04/18/2024	Contact - Telephone call received. Received call from APS worker Maragret Venturis to discuss allegations.
04/19/2024	Contact - Telephone call received. Received call from APS worker Tiffany Pitts stating that she is the assigned worker for these allegations and will be going on site.
05/08/2024	Exit Conference Conducted via email to authorized representative Lou Andriotti.

ALLEGATION:

Resident A was found unattended numerous times and there have been numerous times when resident must wait for long periods of time after pushing the pendant for help.

INVESTIGATION:

On 4/16/2024, the department received the allegations via the BCHS Online Complaint website. The complaint alleged that several times when visiting the Resident [A], she was found slouched over in the wheelchair in her living room. The complaint alleged that on 2/25/2024 at 3:20 p.m., Resident A was found in her wheelchair at her dining table, slouched over with her face in a plate of mac and cheese, a cup of ice cream dipped over beside her face with the ice cream completely melted, running across the table unto the floor, and with her broken arm completely out of its sling hanging in her lap. The complaint alleged that residents

are being left for long periods of time and waiting over an hour for assistance after pushing their pendants.

On 4/22/2024, additional allegations were sent to the department via the BCHS Online Complaint website. The complaint read that care staff to resident ratio during the day shift is 1/18 and on the second floor and 1/12 on the third floor in assistant living. Due to the anonymous nature of this complaint, additional information could not be obtained.

On 4/19/2024, an onsite was completed. I interviewed new administrator Megan Robbins who stated that she is new and not familiar with Resident A. Ms. Robbins stated that the respond time to call lights are “ideally” 5 minutes and the census is 43 at this time.

During the onsite, I interviewed Employee #1 at the facility. Employee #1 stated that care staff consists of five in the morning and evening and four on midnights. Employee #1 stated that she is new and is not familiar with Resident A.

During the onsite, I interviewed Employee #2 at the facility. Employee #2 stated that on the day of the incident with Resident A being found at her dining table, she only needed assistance with getting dress and basic care. She said that Resident A was able to feed herself. She said that lunch was served from 12-12:30. Employee #2 stated that she got Resident A up and got her settled. She said that Resident A wanted to drink her coffee first, then she served her lunch around 1:00 p.m. She said that Resident A’s son found her slouched over with food in her hand and face in the plate. She stated that she spoke to the previous administrator regarding the incident, and she told her that is appeared that she had neglected Resident A by leaving her in the dining room all of that time. Employee #1 explained that all caregivers have walkie talkies to ensure that residents are getting proper care. She said the expected response time to call lights are 5-6 minutes, but they can’t always make it in that time because they may be helping other residents. Her statement was consistent to Ms. Robbins regarding the number of care staff on each shift.

A review of Resident A’s service plan (4/21/2023) read, “needs some assistance, make needs known, 24-hour supervision. Resident is independent with eating, dressing, oral care and grooming. Staff to frequently round on community member throughout shift. This includes passing snack or water, tidying up room, assisting to activity, completing ADLS and when called as needed from call pendant. Wellness checks through night shift. Staff are to initial every two hours that rounding was completed and note the location (daily at 1:00 a.m., 3:00 a.m., 5:00 a.m., 7:00 a.m., 9:00 a.m., 11:00 a.m., 1:00 p.m., 3:00 p.m., 5:00 p.m., 7:00 p.m., 9:00 p.m., 11:00 p.m.).”

An updated service plan for Resident A read, “Please feed as she is unable to feed self. After she has finished eating, please take dishes out of room. Stay with

community member during all meals." This plan was not signed due to Resident A voluntarily discharged on 2/27/2024.

During the onsite, staff observed, and staff reviewed on schedule was consistent to what Ms. Robbins reported.

A review of the *Resident Event Report* revealed:

Occurred	Responded	Response Time
2/15/2024 8:06 AM	2/15/2024 8:40 AM	33 minutes
2/17/2024 10:34 AM	2/17/2024 11:03 AM	29 minutes
2/18/2024 7:30 AM	2/18/2024 8:08 AM	38 minutes
2/18/2024 10:59 AM	2/18/2024 11:44 AM	45 minutes
2/19/2024 7:02 AM	2/19/2024 9:03 AM	120 minutes
2/20/2024 11:39 AM	2/20/2024 12:13 PM	34 minutes
2/21/2024 8:03 AM	2/21/2024 9:03 AM	60 minutes
2/22/2024 12:30 PM	2/22/2024 1:28 PM	57 minutes
2/23/2024 8:18 AM	2/23/2024 8:47 AM	29 minutes
2/23/2024 12:09 PM	2/23/2024 1:38 PM	89 minutes
2/24/2024 7:58 AM	2/24/2024 8:28 AM	30 minutes
2/24/2024 9:16 AM	2/24/2024 10:39 AM	83 minutes
2/25/2024 7:51 AM	2/25/2024 8:36 AM	45 minutes

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.

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.
	(t) "Service plan" means a written statement prepared by the home in cooperation with a resident, the resident's authorized representative, or the agency responsible for a resident's placement, if any, that identifies the specific care and maintenance, services, and resident activities appropriate for the individual resident's physical, social, and behavioral needs and well-being, and the methods of providing the care and services while taking into account the preferences and competency of the resident.
ANALYSIS:	Resident A was found at the table with face down in her food and it is not known as to how long she had been there. However, lunch was served from 12-12:30 p.m. and Resident A was discovered at the table alone with her face in her plate at 3:20 p.m. by her family. The *Resident Event Report* revealed that the longest response time was 120 minutes, and the average response time was 21 minutes. Interview with Ms. Robbins and Employee #2 stated that the expected response time to call lights are 5 minutes. Based on this event report, the call light pendant was not answered in the expected response time putting the residents at risk of not receiving care in a timely manner. Therefore, the facility did not comply with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Toilet was stopped up.

INVESTIGATION:

The complainant alleged that on one occasion they were in the building and another resident complained that her toilet was stopped up and he had to unstop it himself.

Ms. Robbins, Employee #1, and Employee #2 stated that they did not know anything about a toilet being stopped up.

During the onsite, I did not observe any toilets that were stopped up.

APPLICABLE RULE	
R 325.1970	**Water supply systems.**
	(5) The plumbing system shall be designed and maintained so that the possibility of back flow or back siphonage is eliminated.
ANALYSIS:	There was no evidence to suggest that the toilet was stopped up. Therefore, this claim could not be substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS

INVESTIGATION:

Ms. Robbins stated that she is the new administrator. She explained that the previous administrator Jennifer Bishop is no longer there and has been gone for over two to three weeks. She said that she didn't know if forms have been file to complete the change of administrator.

On 4/19/2024, I spoke to licensing consultant Aaron Clum who said that he has not received any forms and has not been notified of any changes.

Employee #2 stated that Ms. Bishop have not been the administrator for three weeks.

APPLICABLE RULE	
R 325.1913	**Licenses and permits; general provisions**
	(2) The applicant or the authorized representative shall give written notice to the department within 5 business days of any changes in information as submitted in the application pursuant to which a license, provisional license, or temporary nonrenewable permit has been issued.
ANALYSIS:	The facility did not provide notification within five days after the change of administrator. Therefore, the facility did not comply with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

05/08/2024

Brender Howard Date
Licensing Staff

Approved By:

05/08/2024

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