GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 30, 2025

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

RE: License #: AH630401935
Investigation #: 2025A1019058
Vista Springs Trillium Village Estate

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. Failure to submit an acceptable corrective action plan will result in disciplinary action. 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.

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) 335-5985.

Sincerely,

Elizabeth Gregory-Weil, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 347-5503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630401935
Investigation #:	2025A1019058
Complaint Receipt Date:	05/28/2025
Investigation Initiation Date:	05/29/2025
Report Due Date:	07/27/2025
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 and 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:	08/01/2024
Expiration Date:	07/31/2025
Capacity:	99
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
The facility is understaffed on second shift.	No
Additional Findings	Yes

III. METHODOLOGY

05/28/2025	Special Investigation Intake 2025A1019058
05/29/2025	Special Investigation Initiated - Letter Emailed licensee requesting current resident roster.
06/10/2025	Inspection Completed On-site
06/13/2025	Inspection Completed-BCAL Sub. Compliance

ALLEGATION: The facility is understaffed.

INVESTIGATION:

On 5/28/25, the department received a complaint that alleged that the facility is short staffed on second shift. The complaint alleged that on 5/4/25, a resident was hurt and had to be hospitalized due to improper staffing (resident name was not provided), on 5/19/25 there wasn't a memory tech in memory care and on 5/24/25 there weren't any caregivers on the second or third floors from 3:00pm-7:00pm. Due to the anonymous nature of the complaint, additional information could not be obtained.

On 6/10/25, I conducted an onsite inspection. I interviewed executive director [Employee 1] at the facility. Employee 1 reported that Employee 2 oversees scheduling, so she was interviewed alongside Employee 1. A resident roster was provided which listed 63 residents (50 residents in the general assisted living area and 13 residents in the memory care unit). Employees 1 and 2 reported that care givers and med passing staff are scheduled on eight-hour shifts. Employee 2 reported that assisted living has two floors (second and third floor) and memory care is on the first floor. Employee 2 reported that at the current census and acuity level, in assisted living there should be two caregivers and two med passers (one per floor) on first and second shift and two caregivers (one per floor) and one med tech (floats between both floors) on third shift. Employee 2 reported that in memory care,

there should be two caregivers and one med tech per shift making seven total care staff for first and second shift and five total care staff during third shift. Employees 1 and 2 reported that med passers are expected to provide care in addition to completing their medication administration duties and reported that depending on the day and shift, there are additional support staff that are cross trained to assist such as the manager on duty and activities staff.

Employees 1 and 2 reported that assisted living residents have call pendants kept on their person and there is a pull cord located in each bathroom to summon staff when assistance is needed. Employee 2 reported that reports are run daily to review the call pendant/pull cord response data and reported that the desired response time is within 10 minutes. Employees 1 and 2 reported that call pendant/pull cord notifications go to phones that staff keep on their person, and the alerts also go to the computer at the concierge desk and to management. Employee 2 reported that staff are required to clear the notifications by resetting the cords or pendants manually to indicate that the resident has been tended to.

While onsite, I reviewed call pendant and pull cord response data for the entire community for the previous five-week period. The following observations were made:

- From 5/1/25-5/10/25, there were 1463 notification events with an average response time of five minutes.
- From 5/11/25-5/17/25, there were 1112 notification events with an average response time of five minutes.
- From 5/18/25-5/24/25, there were 1059 notification events with an average response time of six minutes.
- From 5/25/25-5/31/25, there were 1126 notification events with an average response time of eight minutes.
- From 6/1/25-6/10/25, there were 1576 notification events with an average response time of five minutes.

Regarding the allegations on 5/4/25, Employees 1 and 2 reported that they were fully staffed, but acknowledged that Resident A had a fall that resulted in hospitalization of that resident. Employees 1 and 2 reported that Resident A no longer resides at the facility, but reported that at the time of the incident, she resided in memory care, was mobile and ambulated independently without any assistive device. Employee 2 provided a progress note from the incident that read:

> *Staff was in another cm [community member] room and taking care of other cm's when staff heard cm yelling for help and was waved down by another cm and stated that someone needed help. Staff ran to dining room and found cm on the floor with no explanation. Staff took vitals and checked over cm. Cm stated that her left hip hurt and was yelping in pain when staff tried to touch it. staff then asked cm if they hit their head cm stated they were not for sure. Staff then called family and explained the situation and what happened staff also called upper*

management as well to let them know what was going on. Cm was taken out by emt to get checked over to make sure everything was ok.

Regarding the allegations on 5/19/25, Employee 2 reported that she personally worked in memory care during second shift and I observed one staff scheduled on first shift as a med passer and another staff scheduled on third shift as a med passer. Regarding the allegations on 5/24/25, Employee 2 reported that there were four staff working on floors two and three. I reviewed staff schedules and observed two staff assigned to second floor and two staff assigned to the third floor as Employee 2 attested to; Employee 1 also confirmed there were four staff working during that day and shift.

Staff schedules were obtained for the previous five weeks. Staffing levels observed were consistently lower than the levels described by Employee 2. In follow up correspondence, Employee 1 reported that Employee 2 misspoke about the staffing levels, inadvertently including some of the additional support staff in her numbers. Employee 1 reported that the standard staffing plan should have six total care staff instead of seven on first and second shift and four total care staff instead of five on third shift. After receiving this clarification, the schedules observed were overall consistent with those levels.

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:	Staff attestations combined with a review of staff schedules and emergency response data reveal that staffing is at the levels that were deemed to meet resident need as described by Employee 1. Additionally, progress note documentation from 5/4/25 and review of staffing levels on the three dates referenced by the complainant (5/4, 5/19 and 5/24) do not show that the facility was understaffed during those instances.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

During review of the staff schedules, it was confirmed by Employee 1 that they did not accurately reflect who was working as a caregiver and/or med passer on the following dates/shifts: 5/5/25 (second shift), 5/7/25 (third shift), 5/10/25 (second shift), 5/11/25 (second shift), 5/12/25 (second shift), 5/13/25 (second shift), 5/16/25 third shift, 5/17/25 (third shift), 5/18/25 (second shift), 5/19/25 (second shift), 5/21/25 (second shift), 5/22/25 (second shift) 5/23/25 (second shift), 5/24/25 (first and shift), 5/25/25 (first and second shift), 5/26/25 (first and second shift), 5/29/25 (second shift), 5/30/25 (first, second and third shift), 5/31/25 (first shift), 6/1/25 (first and second shift), 6/2/25 (first shift), 6/3/25 (second shift), 6/4/25 (second and third shift), 6/5/25 (second and third shift) and 6/7/25 (first and third shift).

APPLICABLE RULE	
R 325.1944	**Employee records and work schedules.**
	(2) The home shall prepare a work schedule showing the number and type of personnel scheduled to be on duty on a daily basis. The home shall make changes to the planned work schedule to show the staff who actually worked.
ANALYSIS:	Schedules provided by the facility were not updated to reflect staffing changes on numerous days/shifts for the timeframe reviewed.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon completion of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

06/23/2025

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Elizabeth Gregory-Weil Date
Licensing Staff

Approved By:

06/30/2025

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