GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 25, 2025

Louis Andriotti, Jr.
IP Vista Springs Timber Ridge Opco, LLC
PO Box 4338
East Lansing, MI 48823-9998

RE: License #: AL190383349
Investigation #: 2025A0622048
Vista Springs Lakeside Gardens at Timber Ridge

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) 335-5985.

Sincerely,

Amanda Blasius, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL190383349
Investigation #:	2025A0622048
Complaint Receipt Date:	07/03/2025
Investigation Initiation Date:	07/07/2025
Report Due Date:	09/01/2025
Licensee Name:	IP Vista Springs Timber Ridge Opco, LLC
Licensee Address:	1140 Abbot Rd East Lansing, MI 48823-9998
Licensee Telephone #:	(303) 929-0896
Administrator:	Erin Witter
Licensee Designee:	Louis Andriotti, Jr.
Name of Facility:	Vista Springs Lakeside Gardens at Timber Ridge
Facility Address:	16260 Park Lake Road East Lansing, MI 48823
Facility Telephone #:	(517) 339-2322
Original Issuance Date:	11/14/2016
License Status:	REGULAR
Effective Date:	06/21/2024
Expiration Date:	06/20/2026
Capacity:	20
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Gardenside has been dangerously understaffed on third shift, with only one staff member at times.	Yes
On 07/22/2025, Resident D was transported and admitted into Sparrow Hospital due to having low blood pressure and experiencing pain. During Resident D's examination, there were three fingerprint bruises on her right thigh and upper left leg. Resident A reported she was beaten up (abuser(s) unknown) when she attempted to kill herself.	No

III. METHODOLOGY

07/03/2025	Special Investigation Intake 2025A0622048
07/07/2025	Special Investigation Initiated - On Site
07/15/2025	Contact - Telephone call made to DCW
07/16/2025	Contact - Telephone call made to DCW
07/23/2025	Contact - Document Received- Additional allegations regarding another resident came through. added to current SIR 2025A0622048
07/23/2025	Contact - Document Received- Contacts received from APS, Tom Hilla
07/23/2025	APS has an open investigation.
08/06/2025	Inspection Completed On-site
08/07/2025	Inspection Completed-BCAL Sub. Compliance
08/12/2025	Contact- Phone call to Guardian D1
08/12/2025	Exit conference, voicemail left for licensee designee, Louis Andriotti, Jr.
08/14/2025	Contact- additional documentation requested.
08/18/2025	Contact- documents received.

08/19/2025	Contact- Phone call to direct care workers, Erika Bergman and Destiny Ozier.
08/20/2025	Contact- phone call to Resident B.

ALLEGATION: Gardenside has been dangerously understaffed on third shift, with only one staff member at times.

INVESTIGATION:
On 07/03/2025, I received this complaint through the LARA Bureau of Community and Health Systems online complaint system. According to the complaint, direct care workers have been working with one staff at times. The complaint reported that there are several residents who require two direct care staff members to assist with mobility and/or transfers. The complaint stated that the staff schedule has been altered to look as if enough direct care staff are working in the facility. According to the complaint, there was one staff member working on June 25th, 2025 from 10:45pm-7am despite having multiple residents who require two direct care staff members to assist with transfers and/or mobility.

On 07/07/2025, I completed an unannounced onsite investigation to Vista Springs Lakeside Gardenside Timber Ridge. During the unannounced onsite investigation, I viewed resident documentation, the staff schedule and interviewed direct care workers.

On 07/07/2025, I interviewed administrator Erin Witter in person. She reported that staffing has been difficult because they have had staff quit, walk off third shift and/or not show up for shifts. Ms. Witter reported that it has happened at Gardenside once. She reported that at least two residents require two direct care staff members to assist with transfers and/or mobility. She stated that Resident A requires two direct care staff members to assist him as he is combative and has advanced dementia. Ms. Witter reported that Resident B almost always requires two direct care staff members to assist with transfers and personal care as she is getting weaker. Ms. Witter reported that on 7/07/25, Gardenside had 13 residents and one was in the hospital.

According to the *Assessment Plans for AFC Residents* (assessment plan), Resident A's assessment plan states the following:

"Alert to surroundings: *Needs re-orientation to surrounds, staff to re-orient.*
Controls aggressive behavior: *history of verbal aggression when exit seeking. Needs re-direction.*
Toileting, Bathing, Grooming, Dressing, Personal Hygiene: *Needs staff to assist*
Physical Limitations: *Decreased mobility with dementia, staff to assist with physical limitations.*
Special equipment used: *Walker, Wheelchair, hospital bed"*

According to the *Assessment Plans for AFC Residents,* Resident B's assessment plans states the following:

***"Toileting:** Needs assistance getting on/off toilet and managing continence. Staff to assist.*
***Bathing:** Needs staff assistance*
***Dressing:** Needs staff assistance*
***Walking/mobility:** unable to walk. Staff to provide assistance with mobility.*
***Use of assistive devices:** needs assistance with assistive devices*
***Physical Limitations:** has physical limitations due to decreased mobility. Staff to assist*
***Special equipment used:** wheelchair, hospital bed*
On hospice services, bi-weekly visits."

I viewed Resident A and B's *Health Care Appraisals* and neither of them documented either resident requiring two direct care staff members to assist with transfers, mobility or personal care. I also viewed hospice orders for Resident A and Resident B and there was no documentation stating that the residents need two direct care staff members to assist with transfers, mobility or personal care. I viewed the care plans for Resident A and Resident B and no documentation was found for Resident A stating that he requires two direct care staff members to assist with transfers, mobility or personal care. According to Resident B's care plan it was noted that for assistive devices, she had the following: wheelchair, hospital bed and Hoyer. No statements were found in Resident B's care plan stating that she requires two direct care staff members to assist with transfers, mobility or personal care.

I viewed the staff schedule for Vista Springs Lakeside Gardenside Timber Ridge for June, July and August 2025. According to the staff schedule, on 6/25/25, only direct care workers Kya Young and Destiny Ozier were scheduled from 11pm-7am. According to the schedule received for July, on July 17th and 18th only one direct care worker was scheduled from 11pm-7am. On July 17th the schedule stated that one direct care worker was scheduled to be trained by the other direct care worker, Amber Dziurgot. According to the staff schedule received on 8/11/2025, only one direct care worker was scheduled to work from 11pm-7am.

On 07/07/2025, I interviewed direct care worker (DCW), Sarah Parker in person. She stated that she works at Gardenside at least once a week. DCW Parker reported that all the licensed AFC buildings have been short staffed and she heard that there were times when one staff member worked. DCW Parker stated that an employee is supposed to find coverage, or get someone to stay if they are short on staff members. DCW Parker identified Resident A, Resident B and Resident C as needing two direct care staff members to assist with transfers, mobility and/or personal care.

On 07/07/2025, I interviewed DCW Olivia Lerma in person. She stated that she works first shift and has been employed since April 2025. DCW Lerma reported that

third shift direct care staff will say they changed residents, but the beds will be soaked when she comes in on first shift. DCW Lerma stated that a few weeks ago, she came in for her shift and there was only one staff member working. She explained that she was not sure what happened but heard someone called in. DCW Lerma explained that Residents A and B require two direct care staff members to assist with transfers, mobility and/or personal care. She reported that when she comes in for first shift, Resident A is not always changed, nor are his sheets.

On 07/07/2025, I interviewed direct care worker Zenna Leitelt in person. She reported that she works first shift and sometimes second shift. She stated that she has been employed since January 2025. DCW Leitelt reported that Resident A, Resident B and Resident C require two direct care staff to assist with transfers, mobility and/or personal care. She explained that she had come in for her first shift and there was only one person working at times.

On 07/07/2025, I interviewed Resident B in person. She reported that if she needs assistance she will ring her button and staff will come to help. Resident B reported that she will not wait more than 10 minutes for assistance. Resident B reported no other concerns. Resident B confirmed via interview that she needed staff assistance to get out of bed, transfer to the toilet, her wheelchair and shower. Resident B stated that it can take two staff to assist her with her transfers.

On 07/07/2025, I was informed that the rest of the residents within the home would not be able to be interviewed due to dementia or would not available to be interviewed due to being away from the facility or sleeping.

On 07/15/2025, I interviewed direct care worker, Erika Bergman via phone. DCW Bergman reported that the staff members who should come in and help, do not come in and management is not coming in to help either. DCW Bergman stated that Gardenside has two aggressive residents, where more than one staff member is needed to assist them with their personal care needs. DCW Bergman stated that with one staff member on it puts the residents care and safety at risk. DCW Bergman was interviewed via phone on 8/19/25 and she provided further information regarding Resident A and Resident B's care needs. DCW Bergman stated that Resident B requires a sit to stand. She explained that Resident B's legs are very weak, and she has poor balance. DCW Bergman stated that Resident B is heavier and does not bear weight on her own, therefore two staff members are needed to provide transfers, assistance with using the bathroom and getting into the shower and out. DCW Bergman reported that Resident B will call for assistance during third shift to use the bathroom and since she is tired, her balance and ability to bear weight is not well, therefore two staff members are needed to prevent falls and assist with transfers. DCW Bergman also explained that Resident B does not like to pivot during the middle of the night when using the bathroom. DCW Bergman reported that Resident A is very combative and will "knock you out" if you do not have two staff members to assist with personal care. DCW Bergman explained that Resident A does not like to be changed or rolled over and two staff members or three are

needed to assist with his personal care. DCW Bergman reported that Resident A is also a fall risk and can try and get up and walk by himself often.

On 07/15/2025, I interviewed direct care worker Kya Young via phone. DCW Young reported that on 6/25/25, Gardenside only had one staff member, as DCW Young was working between Vista Springs Lakeside Gardens at Timber Ridge and another licensed facility located on the property. DCW Young reported that she felt overworked, but other workers could not come in because they were already in overtime and management will not come in to help. DCW Young reported that recently they have been through several third shift managers. DCW Young stated that having only one staff member on shift which could put the residents at risk for falling. DCW Young reported that only having one staff member on shift, residents were lacking personal care needs and had to wait longer to be assisted. DCW Young stated that no residents have fallen, but the lack of personal care is occurring as residents may need to wait longer to be assisted.

On 07/16/2025, I interviewed direct care worker, Destiny Ozier via phone. She stated Vista Springs Lakeside Gardens at Timber Ridge is short staffed often and management does not come into help so direct care staff have to “just wing” their shifts. DCW Ozier stated that on 6/25/25 Vista Springs Lakeside Gardens at Timber Ridge was short staffed as she was the only staff member working while DCW Kya Young was running back and forth between Vista Springs Lakeside Gardens at Timber Ridge and another licensed facility located on the property. DCW Ozier stated Vista Springs Lakeside Gardens at Timber Ridge has residents who require two direct care staff members to assist with transfers, mobility and/or personal care. DCW Ozier explained that she heard they are making a mandatory policy for staff to stay or fill in when short staffed. On 8/19/25, I interviewed DCW Ozier via phone for additional information. DCW Ozier stated that Resident A needs two staff members for transfers and to check and change his briefs. DCW Ozier explained that he is very combative, as he hits, kicks and grabs hair when he does not want to be changed during his personal care. DCW Ozier reported that Resident B is heaiver and requires two staff members to assist with transfers from her bed, toilet and shower. She explained that she has poor balance and it’s very hard for her stand up, therefore two staff members are needed for assistance.

On 08/06/2025, I completed an unannounced onsite investigation to Vista Springs Lakeside Gardenside Timber Ridge. During the unannounced onsite investigation, I interviewed direct care worker, Sofia Castillo in person. She reported that she works at Gardenside first shift at times. She reported that on July 7th she came in for first shift and there was only one staff member in the building. DCW Castillo confirmed that there are residents who require two person assists living at Gardenside.

APPLICABLE RULE	
R 400.15206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	Seven direct care workers were interviewed and all seven workers confirmed that Vista Springs Lakeside Gardenside Timber Ridge has at least two residents who require two direct care staff members to assist with transfers, mobility and personal care. Through interviews with two third shift works, DCW Destiny Ozier and Kya Young, it was confirmed that only one staff member was in the building at times on 06/25/2025 during the time frame of 3pm-7am. Administrator Erin Witter also reported that Gardenside has been short staffed on at least one occasion. Also, according to the staff scheduled received, one direct care worker was scheduled to work on July 17th, 18th and August 11th. This is not sufficient direct care staff to meet the needs of Resident A and Resident B specifically but other residents as well.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: On 07/22/2025, Resident D was transported and admitted into Sparrow Hospital due to having low blood pressure and experiencing pain. During Resident D's examination, there were three fingerprint bruises on her right thigh and upper left leg. Resident A reported she was beaten up (abuser(s) unknown) when she attempted to kill herself.

INVESTIGATION:
On 07/23/2025, I received this complaint through the LARA Bureau of Community and Health Systems online complaint system. According to the complaint, adult protective services were investigating allegations for Resident D and sent over the allegations to LARA. According to the complaint, on 07/22/2025, Resident D was transported and admitted into Sparrow Hospital due to having low blood pressure and experiencing pain. During Resident D's examination, there were three fingerprint bruises on her right thigh and upper left leg. Resident A reported she was beaten up (abuser(s) unknown) when she attempted to kill herself. The complaint stated that Guardian D1 was contacted, and he confirmed that recently Resident D was hospitalized at McLaren Hospital due to attempting suicide.

On 07/23/2025, contacts adult protective services have completed were received. According to the contacts, Resident D returned to Vista Springs Lakeside

Gardenside Timber Ridge. The contacts from adult protective services worker, Tom Hilla stated the following:

"[Guardian D1] confirmed [Resident D] was hospitalized at McLaren for two weeks after a suicide attempt. He stated [Resident D] was very violent towards staff during the intervention, but denied she had marks or bruises. [Guardian D1] stated any bruising would have come from when she was at McLaren. [Guardian D1] feels very comfortable with staff at Vista Springs and stated they have [Resident D] placed there for that very reason."

"Spoke with Ann, Social Worker at Sparrow - Main ER, regarding concerns for [Resident D]. She reports [Resident D] was at McLaren about two weeks ago due to suicidal ideations for the day, then went to Oaklawn Psych Hospital from June 26 - July 10, 2025, before being discharged back to Vista Springs."

"Met with [Resident D] and Dawn, PT, in room D - 80 at Sparrow - Main ER, regarding the allegations. [Resident D] was adamant that it was staff at Vista Springs along with law enforcement that left the finger mark bruises. She disclosed she was not acting like herself and had to be restrained before being taken to the hospital. She reports she would later transfer from the hospital to Oaklawn Psych. She did not like Oaklawn. [Resident D] states she is a good Christian woman and was embarrassed that she was not acting like herself. She admits she was having issues, pulling out her IV, and again not acting like herself. Provided her a resource guide and informed her APS will follow up with Guardian D1 along with LARA and law enforcement. Confirmed she wishes to be discharged from the hospital and return to Vista Springs. Confirmed she feels safe there and wishes to continue to receive long - term care there."

On 08/06/2025, I contacted adult protective services worker, Tom Hilla regarding pictures of the bruises and he stated he did not receive any pictures from the hospital.

On 08/06/2025, I completed an unannounced onsite investigation to Vista Springs Lakeside Gardenside Timber Ridge. During the unannounced onsite investigation, I interviewed direct care worker, Michelle Lewis who identified her role as a manager. She reported that she was working at the home when Resident D was having suicidal thoughts and EMS was called. DCW Lewis stated that Resident D stated "she was feeling weird and didn't want to be here anymore." DCW Lewis explained that she was not out of control, didn't need to be restrained and willing went into the ambulance. DCW Lewis stated that she is unaware of any bruises on Resident D's thighs. DCW Lewis stated that before Resident D went to the hospital in June, she had nickel sized dry patches on both of her buttocks and they were treating them. When Resident D returned on 07/10/25, her dry patches had doubled in size and were now open wounds. DCW Lewis provided documentation of the notes of the dry patches before she was admitted to the hospital.

On 08/06/2025, I viewed observation notes for Resident D. On 07/11/2025, it was noted that Resident D returned from the psychiatric facility and had a skin assessment completed. During the skin assessment, it was noted that Resident D had two pressure wounds on the buttocks approximately the size of tennis balls. According to the observation's notes, the primary care physician and power of attorney were notified, and wound care will be ordered by the physician.

On 08/06/2025, I interviewed Resident D in person. She reported that she has a bruise on her back and is not sure what it's from. Resident D stated that when she was at the hospital, she pulled out her IV and all her bruising came from the hospital. Resident D stated that she also walks and talks in her sleep, so she could bump into things at that time. Resident D stated "I have no problems at all with the staff members and they take good care of me." Resident D was unaware if she had any bruising on her legs or thighs.

On 08/12/2025, I interviewed Guardian D1 via phone. He reported that any bruising would have occurred when she was away from Visita Springs Gardenside. He explained that the staff are really great at communicating with him and have provided excellent care for Resident D.

APPLICABLE RULE	
R 400.15308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(b) Use any form of physical force other than physical restraint as defined in these rules.**
ANALYSIS:	Based on contacts received from adult protective services worker, Tom Hilla and interviews with Resident D and Guardian D1 it has been determined that any wounds or bruising were caused from being admitted to the hospital due to suicidal thoughts. Resident D and Guardian D1 reported no concerns regarding direct care workers, using any form of physical force while caring for Resident D.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

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

08/12/2025

Amanda Blasius — Date
Licensing Consultant

Approved By:

08/25/2025

Dawn N. Timm — Date
Area Manager