



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

February 23, 2026

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

RE: License #: AL190383347
Investigation #: 2026A0466013
Vista Springs Grand Terrace at Timber Ridge

Dear Mr. Andriotti, Jr.:

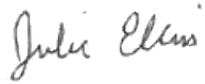
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,

A handwritten signature in cursive script that reads "Julie Elkins".

Julie Elkins, 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 #:	AL190383347
Investigation #:	2026A0466013
Complaint Receipt Date:	01/09/2026
Investigation Initiation Date:	01/09/2026
Report Due Date:	03/10/2026
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:	Jamie Koerner
Licensee Designee:	Louis Andriotti, Jr.
Name of Facility:	Vista Springs Grand Terrace 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:	05/14/2025
Expiration Date:	05/13/2027
Capacity:	20
Program Type:	ALZHEIMERS AGED

II. ALLEGATIONS:

	Violation Established?
Resident A eloped from the facility and was found by the Bath Police Department on 1/04/2026.	No
Direct care workers are not trained to provide care to residents with a colonoscopy bag.	No
Additional findings	Yes

III. METHODOLOGY

01/09/2026	Special Investigation Intake 2026A0466013.
01/09/2026	Special Investigation Initiated – Letter Kimberly Horst.
01/20/2026	Inspection Completed On-site.
01/23/2026	Contact - Document Received new allegation received intake #209049 added.
01/23/2026	Contact - Document Sent/received email to/from administrator Jamie Koerner.
02/18/2026	Contact - Document sent email to administrator Jamie Koerner.
02/23/2026	Contact - Document sent email to administrator Jamie Koerner.
02/23/2026	Exit Conference with licensee designee Louis Andriotti, Jr.

ALLEGATION: Resident A eloped from the facility and was found by the Bath Police Department on 1/04/2026.

INVESTIGATION:

On 01/09/2026, it was reported that Resident A eloped from Vista Springs Grand Terrace at Timber Ridge on 01/04/2026 and was found by the Bath Police Department on 1/04/2026.

On 01/09/2026, I reviewed *CAD report # 26-000911*.

“A missing person report was called in by the facility that a resident was missing for about 30-40 minutes. Subsequently our Bath Twp. Officer Blake Roe, located the resident walking to another building within the complex. She had winter clothing on and didn’t seem distressed.”

I reviewed the *Clinton County E-911 Central Dispatch Communication Events Report* that documented that Bath Police were contacted by facility staff at 9:43 am on 01/04/2026. Bath Police officers were dispatched to Vista Springs Grand Terrace at Timber Ridge and arrived at 9:55am. At 10am, officers had located Resident A near rediscovery building. Resident A had winter clothing on, was not cold and Resident A was returned to staff.

On 01/20/2026, I conducted an unannounced investigation and I reviewed Resident A's record which contained a *Health Care Appraisal* sheet and attached to that was documentation of a hospitalization dated 10/21/2024. The reason for this hospital admission was documented as follows:

"[Resident A] is a 73-year-old female with a history of MDD, major neurocognitive disorder, HLD and hypothyroidism who presents for evaluation and treatment of worsening dementia. Patient is confused and disorganized during interview, answering nonsensically to questions, saying that she needs to look for her children, and is discharged focused. Physical exam was attempted to be completed twice, but she deferred. Will attempt again tomorrow."

I reviewed an *Adult Foster Care (AFC) Incident/Accident Report (IR)* dated 01/04/2026 with the incident occurring at 9:55am. The IR was signed by administrator Koerner but documented that Marlene Hutmacher and Jaquetta Speen were the direct care workers (DCW)s on duty at the time. In the "explain what happened" section of the report it stated:

"On the above date and time, [Resident A] was observed in the Grand Terrace. Shortly thereafter, [Resident A] exited the Grand Terrace through an unlatched door and entered an adjacent building intended to be secured."

In the "action taken by staff" section of the report it stated:

"Staff initiated an immediate search per protocol. 911 was called promptly. A family member was contacted to confirm whether [Resident A's] husband had checked her out; the husband confirmed he did not. [Resident A] was located and secured safely prior to the arrival of emergency responders (less than 30 minutes). Emergency responders arrived and were informed that [Resident A] had already been found and secured. Community Memberial [sc] Services (Glenn) was contacted immediately to assess both building doors and closure functions. [Resident A] was located without injury. No immediate medical intervention was required."

In the "corrective measures taken to remedy/prevent reoccurrence" it stated:

"Policy Review, Staff education, Preventative Measures documented separately in a CAP."

I reviewed Resident A's written *Assessment Plan for AFC Residents* dated 10/28/2024 which documented that Resident A is not independent in the community, she is not able to read or write due cognitive impairment and Resident A requires assistance with all activities of daily living.

I interviewed administrator Jamie Koerner who reported that on 01/04/2026, DCW Hutmacher and DCW Speen were on duty when they could not locate Resident A. Administrator Koerner reported that DCWs did not know her whereabouts for about 25 minutes which is why police were called. Administrator Koerner reported that Resident A was located behind the gated area in another building on the property. Administrator Koerner reported that it was discovered that the side door of this building was not completely latched which was why the alarm did not sound when Resident A exited the building. Administrator Koerner reported that all doors in the building have been inspected and repaired by their maintenance department. Administrator Koerner reported that although Resident A was located in another building, she never left the secure area as the walkway to the other building is gated. Administrator Koerner reported that DCW Hutmacher was provided staff education on "Constant Watch Expectations-Life Safety Standard" on 01/06/2026 and DCW Speen on 01/04/2026.

On 1/23/2026, anonymous Complainant reported that Resident A exited the "secured" building at approximately 9am on 01/04/2026 and wandered outside and was missing for 30-60 minutes. Complainant reported that Resident A was found in an adjacent vacant building which was left unlocked. Complainant reported that facility the doors don't shut and lock properly, so the alarm doesn't sound as expected when exiting the building. Complainant stated this has been a known issue for years as several staff have reported this issue with no resolution. Complainant reported that staff members have written complaints to maintenance to resolve. Complainant reported that the side door also is an issue, and Resident A has been known to get out of this door in the past. Complainant reported that the owner would rather discipline the staff than fix the issue. Complainant reported that this is very dangerous and with that building only having one staff member on third shift it also makes it more of an issue as Resident A wanders and walks all night long. Complainant was anonymous, so no additional information or details regarding the allegation could be gathered.

APPLICABLE RULE	
R 400.685	Resident admission; resident assessment plan; resident care agreement; health care appraisal.
	(2) A licensee shall not accept or care for a resident until a written assessment has been completed. A written assessment plan must include all of the following: (a) The amount of personal care, supervision, and protection required by the resident that is available at the facility.

ANALYSIS:	On 01/04/2026 when Resident A could not be located there were two direct care workers on shift. Based on Resident A's written assessment plan the amount of personal care, supervision, and protection required was available at the facility and therefore there is not enough evidence to establish a violation. Resident A was located within the secured area of the facility grounds and was not harmed.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.693	Incident notification, incident records.
	<p>(1) If a resident has a representative identified in writing on the resident's care agreement, a licensee shall report to the resident's representative within 48 hours after any of the following:</p> <p>(e) Elopement from the facility if the resident's location is unknown.</p> <p>(2) If an elopement occurs, facility staff shall conduct an immediate search to locate the resident. If the resident is not located within 30 minutes after the initiation of the search, staff shall contact law enforcement.</p>
ANALYSIS:	On 01/04/2026 when the whereabouts of Resident A were unknown, direct care staff notified her designated representative and an immediate search was conducted and law enforcement was contacted. Resident A was found within the secured area of the facility property unharmed. Therefore there is not enough evidence to establish a violation.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Direct care workers are not trained to provide care to residents with a colonoscopy bag.

INVESTIGATION:

On 01/23/2026, anonymous Complainant reported that a resident has a colonoscopy bag and no training has been given to direct care worker to adequately care for this. Complainant was anonymous, so no additional information or details regarding the allegation could be gathered.

On 01/23/2026, administrator Koerner reported that she is a registered nurse (RN) and she has provided ostomy care education to direct care workers that included verbal and hands-on training and additional training was provided through Collins Learning. Administrator Koerner reported that she met with all staff today to review

ostomy care expectations and had them complete and sign an ostomy bag competency checklist to confirm understanding and competence. Administrator Koerner reported that she has assigned the Collins Learning ostomy training to all staff to ensure everyone completed it. Administrator Koerner reported she will continue monitoring and validating competencies over the next week, or until all staff working in the Grand Terrace Building are deemed competent. Administrator Koerner reported that these steps are being taken to ensure safe, consistent care, proper documentation, and the continued dignity and well-being of Resident B. Administrator Koerner reported hiring a care scheduler/nightshift supervisor who will be helping with training competencies and testing. Administrator Koerner reported a licensed practical nurse (LPN) was hired who will also be assisting in delivering education to staff and monitoring competency. Administrator Koerner reported a commitment to providing education to all staff members related to colostomy care. Administrator Koerner provided proof of training in colostomy care for the following 17 staff members: Da'Maya Ashburn, Amber Brown, Clementine Cummings, Cassandra Gerard, Patience Dolo- Howe, Vedrana Kaletovic, Kylee Kiczenski, Ashli Lee, Zenna Leitelt, Maria Lightner, Mari Lopez, Melissa Rahl, Zuvena Schleuter, Jaquetta Speed, Salamutu Swaray, Sarah Taylor and Lauren Winston.

APPLICABLE RULE	
R 400.689	Resident health care.
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other designated health care professional.
ANALYSIS:	Administrator Koerner reported that she is a registered nurse (RN) and she has provided ostomy care education for direct care workers that included verbal and hands-on training and additional training was provided through Collins Learning. Administrator Koerner provided proof of training in colostomy care for 17 staff members. Therefore there is not enough evidence to establish a violation.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDING:

INVESTIGATION:

On 01/20/2026, I conducted an unannounced investigation and I reviewed Resident A's written *Assessment Plan for AFC Residents* dated 10/28/2024 completed by "Ennilutter LPN." I noted this document was signed by Resident A's designated representative on 10/28/2024 and the space labeled "signature of licensee" was signed on 10/28/2024 by "Ennilutter." The licensee designee that is documented in the facility file in the Bureau Information Tracking System (BITS) is Louis Andriotti,

Jr. therefore, this document was not signed by the licensee designee. Additionally, Resident A's written assessment plan was not updated annually as required.

APPLICABLE RULE	
R 400.685	Resident admission; resident assessment plan; resident care agreement; health care appraisal.
	(4) A written assessment plan must be completed with and signed by the resident or the resident's designated representative, responsible agency if applicable, and the licensee at the time of admission and annually thereafter. A licensee shall maintain a copy of the resident's most recent assessment plan on file at the facility for up to two years after discharge.
ANALYSIS:	Resident A's written <i>Assessment Plan for AFC Residents</i> documented a completed date of "10/28/2045" where it stated, "date assessment plan was completed." Resident A's designated representative signed the assessment plan on 10/28/2024. Someone else signed in the licensee designee portion of the report on 10/28/2024 instead of the licensee designee as required. Further there is no documentation that the assessment plan was updated annually as required.
CONCLUSION:	VIOLATION ESTABLISHED

INVESTIGATION:

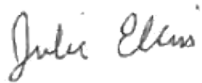
On 01/20/2026, I conducted an unannounced investigation and I reviewed Resident A's record which contained a *Health Care Appraisal* dated 10/28/2024 with an attachment of a hospitalization dated 10/21/2024. It is assumed that this was the admission physical however it was not updated annually as this was the only *Health Care Appraisal* available for review in Resident A's record at the time of inspection.

APPLICABLE RULE	
R 400.685	Resident admission; resident assessment plan; resident care agreement; health care appraisal.
	(10) A resident or resident's designated representative shall provide a written health care appraisal or a medical discharge summary by an appropriate health care professional that is completed within the 90-day period before admission. A written health care appraisal must be completed at least annually thereafter. If a written health care appraisal is not available at the time of an emergency

	admission, a licensee shall require that the appraisal be completed no later than 30 days after admission.
ANALYSIS:	Resident A's <i>Health Care Appraisal</i> dated 10/28/2024 was the only <i>Health Care Appraisal</i> available for review in Resident A's record at the time of inspection. There is no documentation that the <i>Health Care Appraisal</i> was updated annually as required.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

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



02/23/2026

Julie Elkins
Licensing Consultant

Date

Approved By:



02/23/2026

Dawn N. Timm
Area Manager

Date