GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 13, 2021

Louis Andriotti, Jr.
Vista Springs Ctr/Memory Care & Rediscovery
3736 Vista Springs Ave.
Grand Rapids, MI 49525

RE: License #: AH410400149
Investigation #: 2021A1010040
Vista Springs Ctr/Memory Care & Rediscovery

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 (616) 356-0183.

Sincerely,

Lauren Wohlfert, Licensing Staff
Bureau of Community and Health Systems
350 Ottawa Ave NW Unit 13
Grand Rapids, MI 49503
(616) 260-7781
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH410400149
Investigation #:	2021A1010040
Complaint Receipt Date:	07/09/2021
Investigation Initiation Date:	07/12/2021
Report Due Date:	09/08/2021
Licensee Name:	Vista Springs Northview, LLC
Licensee Address:	Ste 110 2610 Horizon Dr. SE Grand Rapids, MI 49546
Licensee Telephone #:	(616) 364-4690
Administrator:	Jennifer Slater
Authorized Representative:	Louis Andriotti
Name of Facility:	Vista Springs Ctr/Memory Care & Rediscovery
Facility Address:	3736 Vista Springs Ave. Grand Rapids, MI 49525
Facility Telephone #:	(616) 364-4690
Original Issuance Date:	03/04/2020
License Status:	REGULAR
Effective Date:	09/04/2020
Expiration Date:	09/03/2021
Capacity:	56
Program Type:	ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A's medications were not ordered in a timely manner; therefore, not administered as prescribed.	Yes

III. METHODOLOGY

07/09/2021	Special Investigation Intake 2021A1010040
07/12/2021	Special Investigation Initiated - Letter APS referral emailed to Centralized Intake
07/12/2021	APS Referral APS referral emailed to Centralized Intake
07/13/2021	Contact - Document Received Email received from assigned APS worker Emily Graves
07/20/2021	Contact - Telephone call received Received telephone call from assigned APS worker Emily Graves
07/21/2021	Contact - Telephone call made Message left for the complainant, a call back was requested
07/21/2021	Inspection Completed On-site
07/21/2021	Contact - Document Received Received Resident A's service plan, staff notes, and MARs
08/13/2021	Exit Conference

ALLEGATION:

Resident A's medications were not ordered in a timely manner; therefore, not administered as prescribed.

INVESTIGATION:

On 7/9/21, the Bureau received the allegations from the online complaint system. The complaint read, [Resident A] was admitted on Aug 7, 2020. Facility was only giving resident his insulin shot at bed time, he is supposed to have his shot 4 times a day. Resident was taken to the hospital for having high sugar levels sometime in November. Resident's medication are not ordered in a timely manner and he is left without his medications due to his medications being ordered late. Resident is being sent to the hospital because staff believes resident is having seizures. It was report to complainant that resident's medication is in a different building. There is a concern that the care the resident is being given inadequate [sic] care from the staff and as a result, resident is ending up in poor health."

On 7/12/21, I emailed an Adult Protective Services (APS) referral to Centralized Intake.

On 7/20/21, I received a telephone call from assigned APS worker Emily Graves. Ms. Graves reported she went to the facility and observed Resident A's medication administration records (MARs). Ms. Graves reported Resident A's MARs outlined what medications staff administered to him. Ms. Graves stated there was one reported incident in which the pharmacy did not deliver Resident A's insulin timely.

Ms. Graves said she was unable to engage Resident A in meaningful conversation because he was nonverbal. Ms. Graves reported she interviewed the complainant by telephone. Ms. Graves stated the complainant was concerned Resident A received poor care at the facility because he was in and out of the hospital several times.

Ms. Graves reported Resident A recently started to receive hospice services through Kindred.

On 7/21/21, I interviewed managing partner De'Lon Barry at the facility. Mr. Barry reported Resident A died on 7/15 while he received hospice services through Kindred. Mr. Barry stated he did not know specific information regarding Resident A's medications.

On 7/21/21, I interviewed wellness director Toriyon Mitchell at the facility. Mr. Mitchell reported Resident A's physician changed his insulin order frequently and the facility's contracted pharmacy delivered insulin that was not consistent with the physician order. Mr. Mitchell said the facility maintained frequent contact with Resident A's physician and the pharmacy to get the issue resolved. Mr. Mitchell stated after Resident A was admitted to the hospital at the beginning of May, the pharmacy changed Resident A's insulin order without confirmation from his physician. Mr. stated the facility worked through the insulin prescription discrepancy with the pharmacy and Resident A's physician.

Mr. Mitchell reported Resident A was prescribed Homolog at 8:00 am, 12:00 pm, and 5:00 pm and Lantis at 8:00 pm. Mr. Mitchell stated staff were to take Resident A's blood sugar at 12:00 am, 6:00 am, 12:00 pm, and 6:00 pm,

Mr. Mitchell said Resident A never went without his prescribed insulin and it was administered as prescribed. Mr. Mitchell reported there was an incident when the pharmacy delivered Resident A's prescribed Depakote to the wrong building on the facility's campus. Mr. Mitchell stated it took staff several days to locate the medication.

Mr. Mitchell provided me with a copy of Resident A's May, June, and July MARs. The MARs read Resident A's prescribed insulin was administered as prescribed. The MARs read resident A's prescribed "DIVALPROEX 125 MG CAPSULE (DEPAKOTE 125MG SPINKLE) take 1 capsule by Mouth Twice Daily" was not administered on 6/29, 6/30, 7/1, 7/2, 7/3, 7/4, 7/5, 7/6, 7/7, and 7/8. Staff documented the reason this medication was not administered was because the medication was "not available" or "not in cart." On 7/4, staff documented "med not in cart- pharmacy notified."

On 7/21/21, I interviewed medication technician (med tech) Tegan Jackson at the facility. Ms. Jackson's statements were consistent with Mr. Mitchell. Ms. Jackson reported Resident A went approximately one to two weeks without his prescribed Depakote because it was delivered to the wrong building. Ms. Jackson stated Resident A was prescribed Depakote for seizures. Ms. Jackson reported Resident A did have a seizure and was admitted to the hospital.

On 7/21/21, I left a voicemail for the complainant. The complainant has not returned my telephone call to date.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(1) Medication shall be given, taken, or applied pursuant to labeling instructions or orders by the prescribing licensed health care professional.
ANALYSIS:	The interviews with Mr. Mitchell, Ms. Jackson, along with review of resident A's June and July MARs, revealed he went several days without his prescribed Depakote. Although Resident A's MAR documented that the pharmacy was notified Resident A did not have his Depakote, he went an additional four days without it.
CONCLUSION:	**VIOLATION ESTABLISHED**

I attempted to share the findings of this report with licensee authorized representative Lou Andriotti by telephone several times. Mr. Andriotti was

unavailable, therefore I left a voicemail informing Mr. Andriotti there was a finding and to contact me by telephone if he had any questions.

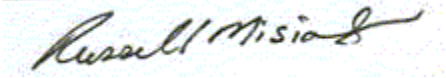
IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

7/28/21

Lauren Wohlfert Date
Licensing Staff

Approved By:



7/28/21

Russell B. Misiak Date
Area Manager