GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 20, 2021

Louis Andriotti, Jr.
IP Vista Springs Timber Ridge Opco, LLC
Ste 110
2610 Horizon Dr. SE
Grand Rapids, MI 49546

RE: License #: AL190383349
Investigation #: 2021A0577041
Vista Springs Timber Ridge, LLC

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 (231) 922-5309.

Sincerely,

Bridget Vermeesch

Bridget Vermeesch, Licensing Consultant
Bureau of Community and Health Systems
1919 Parkland Drive
Mt. Pleasant, MI 48858-8010
(989) 948-0561

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL190383349
Investigation #:	2021A0577041
Complaint Receipt Date:	07/27/2021
Investigation Initiation Date:	07/27/2021
Report Due Date:	09/25/2021
Licensee Name:	IP Vista Springs Timber Ridge Opco, LLC
Licensee Address:	Ste 110 2610 Horizon Dr. SE Grand Rapids, MI 49546
Licensee Telephone #:	(303) 929-0896
Administrator:	Wendy Mehan
Licensee Designee:	Louis Andriotti Jr
Name of Facility:	Vista Springs Timber Ridge, LLC
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:	05/14/2021
Expiration Date:	05/13/2023
Capacity:	20
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Facility is short staffed and cannot meet the needs of the residents in care.	Yes

III. METHODOLOGY

07/27/2021	Special Investigation Intake 2021A0577041
07/27/2021	Contact - Telephone call made- Clinton County Central Dispatch.
07/27/2021	Contact - Document Received Email from Clinton County Contral Dispatch with document attached.
07/27/2021	Special Investigation Initiated – Telephone call-Interview with Complainant.
08/09/2021	Inspection Completed On-site- Interviewed residents and staff.
08/18/2021	Inspection Completed On-site- Interview of administrator, staff, and review of paperwork.
08/20/2021	Contact - Telephone call made- Interview with staff.
08/20/2021	Contact-Telephone call made- Left Messages with staff.
08/25/2021	Exit Conference conducted with licensee designee Lou Andriotti.
08/25/2021	Inspection Completed-BCAL Sub. Compliance
09/01/2021	Contact-Telephone call received- Interview with staff.
09/13/2021	Contact-Document Sent- Email to Keith Fisher requesting medication training records for staff.
09/14/2021	Contact-Document Received- Email from Kimberly Horst, HFA Consultant.
09/15/2021	Contact-Telephone call made- Interview with staff.

ALLEGATION: Facility is short staffed and cannot meet the needs of the residents in care.

INVESTIGATION:

On July 27, 2021, a complaint was received reporting that on July 25, 2021, there was only one direct care staff member in the building for 15 residents. It was reported Wendy Mehan, Administrator was contacted and refused to come in and work the floor, nor was another staff called into work. The complaint reported an activity person who is not qualified to provide care arrived around 9am to assist. The complaint reported the paging system was not working so a resident who was toileting was left on the toilet for a lengthy period of time. More specifically, the complaint reported a resident had put themselves on the toilet so direct care staff members were not notified. The resident allegedly sat on the toilet for 1.5 hours before direct care staff members realized the resident was on the toilet. The complaint also alleged another resident could not contact a direct care staff member so the resident called 911 for assistance. The complaint reported the facility is short staffed frequently.

On July 27, 2021, I contacted Clinton County Central Dispatch (CCCD) and spoke with Ross Lauback, Director of CCCD who verified they received a call from a resident who resides at Vista Springs Timber Ridge, LLC was received on July 25, 2021, at 10:19pm. Mr. Ross provided me with a written report of the call and the report documented the following information:

- Call Received: 07/25/21 22:19:15, location-16260 Park Lake Rd, Gardenside BLDS Rm 107; Caller- [Resident A]; Nature-request for service, resident has been trying to get someone to come and assist them for an hour now and no one has come to help, requesting for us to call them and have someone come to her room. CCCD called facility and they will have someone go and check on resident in room 107.

On August 08, 2021, I completed an unannounced onsite investigation and found two direct care staff currently working at the time of the investigation. I interviewed Resident A who reported needing assistance from two direct care staff when transferring from bed to Hoyer lift, Hoyer lift to chair, toilet, and bed due to being non-weight baring on their right leg. Resident A reported not remember calling 9-1-1 for assistance because Resident A could not find a direct care staff member for assistance. Resident A reported not being sure how many direct care staff usually work per shift. Resident A could not definitively report if one direct care staff member has ever transferred Resident A.

On August 08, 2021, I interviewed Resident B and Resident C who reported this morning around 6:55am, Resident B needed assistance with getting out of bed and going to the bathroom. Resident B stated he pushed the call button to page direct care staff for help and waited for over an hour with no direct care staff member coming to help. Resident B reported he had to wake Resident C to go and find staff to assist Resident B. Resident B and Resident C reported two staff came to the room to assist

Resident B to the bathroom. Resident B and Resident C reported there have been times when there is only one staff working because someone has called in or did not show for their shift. Resident B reported he has been transferred by one staff using the Hoyer Lift even though there are supposed to be two staff assisting with transfers and when using the Hoyer Lift. Resident B and Resident C reported last night on August 07, 2021, there was only one staff working the midnight shift and that direct care staff member transferred Resident B by themselves according to Resident B. Resident C reported she feels there needs to be three staff providing care during the day and two during the night.

On August 08, 2021, I interviewed Resident D who stated, "I feel we need more help; it takes them a long time to get to us when we call for help." Resident D reported there are usually at least two direct care staff working per shift, but there have been times when only one direct care staff is working. Resident D reported one day she wanted to take a shower and was told three times by a direct care staff member that the staff member could not give Resident D a shower because the direct care staff member was working by themselves and did not have the time to provide showers.

On August 08, 2021, I interviewed Staff 1 who reported she works first shift from 7:00am-7:00pm as a medication technician. Staff 1 reported there used to be three direct care staff on the floor and now there are only two direct care staff due to staff shortages. Staff 1 reported she has always had two staff working with her. Staff 1 reported not being aware of shifts with only one direct care staff working.

On August 18, 2021, I conducted a second unannounced onsite investigation and observed two direct care staff were working. I met with new Administrator Keith Fisher and reviewed Resident A's and Resident B's *Assessment Plan for AFC Residents* which documented both residents required the use of a Hoyer lift for transferring as well as requiring two direct care staff to assist with transfers and mobility. I also reviewed the *Resident Register* documenting there are currently 16 residents living in the facility and during July 2021 there were 15 residents. I requested to review and receive a copy of the staff schedules for those time frames but staffing schedules were not provided.

On August 18, 2021, I interviewed Staff 2 who reported there currently are two residents who required two-person assistance when transferring. Staff 2 reported the shift from 7:00am-7:00pm usually has two direct care staff working but the shifts 7:00pm-7:00am or 3:00pm-11:00pm are the shifts that end up with only having one direct care staff member working. Staff 2 reported "management" is supposed to cover or fill in when a direct care staff member calls in leaving only one staff working with residents but Staff 2 stated management does not work or cover shifts on a consistent basis. Staff 2 reported management will provide staff with a walkie talkie and advise them to page the other adjacent facilities to request staff from another facility to come over to assist when needed. Staff 2 reported there have been a couple of times during which Staff 2 was the only staff on the floor. Staff 2 also stated experiencing a three- or four-hour period without a medication technician on the floor to provide medications if needed. Staff 2 could not recall the dates during which Staff 2 worked alone or without a medication

technician available to pass medication to residents. Staff 2 reported based on the needs of residents there needs to be three staff during resident waking hours and two staff during sleeping hours.

On August 18, 2021, I interviewed Staff 3 who reported Resident A and Resident B require two-person lift assistance when transferring. Staff 3 reported the facility has always had two direct care staff on the floor when working but Staff 3 stated recently arriving to work and witnessing only one staff working the floor due to no call/no show of second scheduled staff. Staff 3 reported there needs to be three direct care staff working the floor during the day due to the expectations of what staff are supposed to provide such as assistance in the kitchen with resident meals, setting and clearing of tables, and providing direct personal care to residents. Staff 3 stated, “two staff are not enough to meet the needs of the residents during waking hours.”

On August 20, 2021, I interviewed Staff 4 who reported the facility is very short staffed and they are splitting medication technicians between buildings, leaving one direct care staff on the floor in each building for extended periods of time. Staff 4 reported there are two residents who require two-person assistance from staff. Staff 4 reported on August 08, 2021, there was one direct care staff working from 11:00pm-7:00am. Staff 4 reported there were two separate occasions in July when only one direct care staff worked from 7:00am-3:00pm due to staff calling in or no-call/no-show and management not being able to cover the shift. Staff 4 reported in August 2021, Staff 4 arrived to work at 11:00am and the only person working was the medication technician from 7:00am-11:00am.

On September 02, 2021, I received and reviewed a copy of the staff schedule which documented on July 25, 2021, there was one med technician scheduled from 7:00am-7:00pm and 7:00pm-7:00am a direct care staff scheduled from 3:00pm-11:00pm and 11:00pm-7:00am, but no direct care staff was scheduled from 7:00am-3:00pm. Per the staff schedule for July 2021, on July 03, 2021, there was no medication technician scheduled from 7:00am-7:00pm, July 15 and 18, 2021 there was only a medication technician on the floor from 3:00pm-7:00pm and no direct care staff.

I interviewed Staff 5 who reported on July 25, 2021, they worked 7:00am-7:00pm as a medication technician and was the only staff on the floor, no other direct care staff was scheduled to work from 7:00am-3:00pm. Staff 5 reported they called multiple people in supervision requesting help and did not receive any help. Staff 5 reported the company policy is if no direct care staff is available then management is supposed to work the floor and management reported they were not willing to come in. Staff 5 reported around 9:00am an activity person arrived at the facility but was not trained in direct care and also had a weight restriction so could not assist with transfers. Staff 5 reported the power kept going in and out which made the resident pager system malfunction thus residents could not push their call buttons for assistance. Staff 5 reported a call was received from Central Dispatch notifying them of Resident A calling 911 because Resident A needed assistance in her bedroom and could not contact staff. Staff 5 reported Resident A requires two person assistance with transferring but Staff 5 had to

transfer Resident A by themselves because Staff 5 was the only person working. Staff 5 reported while doing room checks Staff 5 found another resident who had gotten on the toilet but was not able to get off the toilet. Staff 5 stated this resident had been sitting on the toilet for about 1.5 hours. Staff 5 reported they have worked the floor by themselves one other time but cannot remember the specific date.

On September 13, 2021, I emailed Administrator Keith Fisher requesting copies of medication technicians training records but received no response.

On September 14, 2021, I received an email from Kimberly Horst, Home for Aged Licensing Consultant reporting she was at the facility on September 14, 2021 and found only one medication technician working with no direct care staff.

On September 15, 2021, I interviewed Staff 2, Staff 6, and Staff 7. Staff 2 reported at the beginning of July 2021, Staff 2 who was trained as a direct care staff, also became trained as a medication technician. Staff 2 and Staff 6 both reported that unless a direct care staff is trained as a medication technician, direct care staff members do not have access to the medication cart keys and thus resident medication. Consequently, Staff 2 or Staff 6 both reported when they worked alone as a direct care staff member, they did not have access to resident medication and could not pass resident medication. Both reported being directed to call an adjacent licensed AFC to have the medication technician from that building come and administer medications as needed in their building. Staff 2 and Staff 6 reported the medication technicians have been scheduled as floaters between buildings due to the staff shortage. Staff 7 reported on August 2, 2021, they were scheduled as a direct care staff as the medication technician did not show so Staff 7 was given the medication cart keys and directed to pass medications to residents without medication training. Staff 7 reported being trained as a medication technician in mid-August by shadowing a medication technician for three days.

APPLICABLE RULE	
R 400.15206	**Staffing requirements.**
	(1) The ratio of direct care staff to residents shall be adequate as determined by the department, to carry out the responsibilities defined in the act and in these rules and shall not be less than 1 direct care staff to 15 residents during waking hours or less than 1 direct care staff member to 20 residents during normal sleeping hours.

ANALYSIS:	It has been determined by the department that the ratio of direct care staff to residents was not adequate to provide the care required by Resident A and Resident B at the time of the investigation. Resident A and Resident B require use of two direct care staff and a Hoyer Lift when being transferred. Per Resident A's and Resident B's *Assessment Plan for AFC Residents* and interviews with direct care staff both Resident A and Resident B require two direct care staff members to assist transferring and when using Resident A and Resident B's Hoyer Lifts. Other examples of inadequate staff to resident ratio found during the investigation include: Resident D not being able to shower on one occasion due to only one direct care staff member working and not having time to shower Resident D, Resident B was transferred by one direct care staff member, Resident A called 911 on July 25, 2021, after needing help in her room and being unable to successfully locate a direct care staff member, and on August 8, 2021, Resident B received assistance from another resident to use the restroom after being unable to successfully locate a direct care staff member for assistance. Multiple direct care staff members were interviewed and direct care staff schedules were reviewed and confirmed that there were dates/times during July 2021 where only one direct care staff member worked during a shift and on July 25, 2021, there was no direct care staff member listed on the staff schedule from 7AM-3PM. Kimberly Horst, Home for Aged Licensing Consultant observed one medication technician working the floor by themselves on September 14, 2021. During these times there were more 15 or more residents living in the facility which requires at least two direct care staff members to be on duty during waking hours.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon the receipt of an acceptable corrective action plan, I recommend continuation of the current status of the license of this AFC adult large group home, capacity of 20.

09/15/2021

Bridget Vermeesch Date
Licensing Consultant

Approved By:

09/21/2021

Dawn N. Timm Date
Area Manager