GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 21, 2021

Louis Andriotti, Jr.
Vista Springs Holland Meadows LLC
2610 Horizon Dr. SE
Grand Rapids, MI 49546

RE: License #:	AH700397994
Investigation #:	2021A1021051
	Vista Springs Holland Meadows

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) 284-9730.

Sincerely,

Kimberly Horst, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH700397994
Investigation #:	2021A1021051
Complaint Receipt Date:	09/16/2021
Investigation Initiation Date:	09/17/2021
Report Due Date:	11/16/2021
Licensee Name:	Vista Springs Holland Meadows LLC
Licensee Address:	Ste 110 2610 Horizon Dr. SE Grand Rapids, MI 49546
Licensee Telephone #:	(616) 259-8659
Administrator:	Louis Andriotti, Jr.
Authorized Representative	Louis Andriotti, Jr
Name of Facility:	Vista Springs Holland Meadows
Facility Address:	445 104th Avenue Holland, MI 49423
Facility Telephone #:	(616) 795-9693
Original Issuance Date:	06/04/2020
License Status:	REGULAR
Effective Date:	02/01/2021
Expiration Date:	01/31/2022
Capacity:	56
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Facility is restricting visitors.	No
Facility issued improper discharge.	Yes
Resident A received inadequate care.	Yes
Additional Findings	Yes

III. METHODOLOGY

09/16/2021	Special Investigation Intake 2021A1021051
09/17/2021	Special Investigation Initiated - Telephone Interviewed complainant by telephone
09/17/2021	APS Referral Sent referral to APS
09/20/2021	Inspection Completed On-site
09/22/2021	Contact-Telephone call made Interviewed authorized representative Louis Andriotti, Jr.
	Exit Conference

ALLEGATION:

Facility is restricting visitors.

INVESTIGATION:

On 9/16/21, the licensing department received a complaint with allegations the facility is restricting visitation.

On 9/17/21, the allegations in this report were sent to centralized intake at Adult Protective Services (APS).

On 9/17/21, I interviewed the complainant by telephone. The complainant alleged they were initially allowed into the facility but have since been restricted. The complainant alleged the facility does not allow them to see Resident A's room.

On 9/20/21, I interviewed administrator Ashley Kiss at the facility. Ms. Kiss reported Resident A admitted to the facility on Thursday, 9/2. Ms. Kiss reported the facility allows family members two days to help with moving the resident in and getting them settled. Ms. Kiss reported the family continued to come into the facility through that weekend and told staff they had permission to do so. Ms. Kiss reported management is not on site during the weekend and was not made aware family was visiting with Resident A in his room. Ms. Kiss reported the facility had a covid-19 outbreak in August and therefore has set visitation rules. Ms. Kiss reported visitors are to complete Covid-19 screening upon entry and visit with the resident in one of the common visitation areas. Ms. Kiss reported families are to make an appointment for the visit and are to wear a mask during the visit. Ms. Kiss reported if the resident is on hospice or compassionate care, family can visit in the room. Ms. Kiss reported Resident A's family has been upset with the visitation rules because they report they were not informed of these rules prior to moving in. Ms. Kiss reported the family was educated on the visitation rules. Ms. Kiss reported they are not trying to hide anything from family members but are trying to keep the residents safe from Covid19. Ms. Kiss denied the allegations that the facility is restricting visitation.

On 9/20/21, I interviewed manager Ashlynn Postma. Ms. Postma's statements were consistent with those made by Ms. Kiss.

On 9/20/21, I interviewed receptionist Ethyln Ottley-Farrell at the facility. Ms. Ottley-Farrell reported all visitors are to make an appointment for visitation. Ms. Ottley-Farrell reported if they do not make an appointment, the facility will try to accommodate them. Ms. Ottley-Farrell reported upon entering the facility, the visitor is to complete the Covid-19 screening and have the visit in one of the common visitation areas. Ms. Ottley-Farrell reported herself or another employee will get the resident and bring the resident to the visiting area. Ms. Ottley-Farrell reported if a resident is on hospice services, they can go to the resident's room. Ms. Ottley-Farrell reported this policy was re-enacted after the facility had their recent Covid-19 outbreak in August. Ms. Ottley-Farrell reported the facility is not restricting visitation.

On 9/20/21, I interviewed caregiver Kate Fish at the facility. Ms. Fish's statements on visitation was consistent with those made by Ms. Kiss and Ms. Ottley-Farrell.

On 9/21/21, I interviewed authorized representative Louis Andriotti, Jr. by telephone. Mr. Andriotti reported he was contacted by Resident A's family with accusations of neglect and lack of care being provided to Resident A. Mr. Andriotti reported he went above management at the facility and allowed Resident A's family access to Resident A's room. Mr. Andriotti reported he did this so that the family would feel better about having Resident A in the facility and to ensure he was getting proper

care. Mr. Andriotti reported this access was just a one-time access and then family was to follow facility visitation protocols.

I reviewed QSO-20-39-NH Nursing Home Visitation - COVID-19. The order read,

> *"Visitation can be conducted through different means based on a facility's structure and residents' needs, such as in resident rooms, dedicated visitation spaces, outdoors, and for circumstances beyond compassionate care situations. Regardless of how visits are conducted, there are certain core principles and best practices that reduce the risk of COVID-19 transmission:*
>
> *Screening of all who enter the facility for signs and symptoms of COVID-19 (e.g., temperature checks, questions about and observations of signs or symptoms), and denial of entry of those with signs or symptoms or those who have had close contact with someone with COVID-19 infection in the prior 14 days (regardless of the visitor's vaccination status)*
>
> *Hand hygiene (use of alcohol-based hand rub is preferred)*
>
> *Face covering or mask (covering mouth and nose) and social distancing at least six feet between persons, in accordance with CDC guidance*
>
> *Instructional signage throughout the facility and proper visitor education on COVID19 signs and symptoms, infection control precautions, other applicable facility practices (e.g., use of face covering or mask, specified entries, exits and routes to designated areas, hand hygiene)*
>
> *Cleaning and disinfecting high-frequency touched surfaces in the facility often, and designated visitation areas after each visit*
>
> *Appropriate staff use of Personal Protective Equipment (PPE)*
>
> *Effective cohorting of residents (e.g., separate areas dedicated to COVID-19 care) • Resident and staff testing conducted as required at 42 CFR § 483.80(h) (see QSO20-38-NH Revised)*
>
> *Facilities should consider how the number of visitors per resident at one time and the total number of visitors in the facility at one time (based on the size of the building and physical space) may affect the ability to maintain the core principles of infection prevention. If necessary, facilities should consider scheduling visits for a specified length of time to help ensure all residents are able to receive visitors. During indoor visitation, facilities should limit visitor movement in the facility. For example, visitors should not walk around different halls of the facility. Rather, they should go directly to the resident's room or designated visitation area. Visits for residents who share a room should not be conducted in the resident's room, if possible. For situations where there is a roommate and the*

health status of the resident prevents leaving the room, facilities should attempt to enable in room visitation while adhering to the core principles of COVID-19 infection prevention."

The Michigan Department of Health and Human Services issued the following*:*

The new order requires residential facilities to comply at all times with Centers for Medicare and Medicaid Services (CMS) guidance applicable to nursing homes included in CMS memorandum QSO-20-39-NH.

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents;**
	(1) A health facility or agency that provides services directly to patients or residents and is licensed under this article shall adopt a policy describing the rights and responsibilities of patients or residents admitted to the health facility or agency. Except for a licensed health maintenance organization, which shall comply with chapter 35 of the insurance code of 1956, 1956 PA 218, MCL 500.3501 to 500.3580, the policy shall be posted at a public place in the health facility or agency and shall be provided to each member of the health facility or agency staff. Patients or residents shall be treated in accordance with the policy.
For Reference: MCL 333.20201	**(2) (k) A patient or resident is entitled to associate and have private communications and consultations with his or her physician or a physician's assistant to whom the physician has delegated the performance of medical care services, attorney, or any other person of his or her choice and to send and receive personal mail unopened on the same day it is received at the health facility or agency, unless medically contraindicated as documented in the medical record by the attending physician or a physician's assistant to whom the physician has delegated the performance of medical care services. A patient's or resident's civil and religious liberties, including the right to independent personal decisions and the right to knowledge of available choices, shall not be infringed and the health facility or agency shall encourage and assist in the fullest possible exercise of these rights. A patient or resident may meet with, and participate in, the activities of social, religious, and community groups at his or her discretion, unless**

	medically contraindicated as documented in the medical record by the attending physician or a physician's assistant
ANALYSIS:	The facility has enacted a visitation policy due to their recent Covid-19 outbreak that is consistent with the guidelines in QSO-20-39-NH Nursing Home Visitation - COVID-19.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Facility issued improper discharge.

INVESTIGATION:

The complainant alleged Resident A was issued 30-day discharge notice. The complainant alleged the discharge notice is due to miscommunication between management and Resident A's family.

Ms. Kiss reported the facility cannot meet the needs of Resident A. Ms. Kiss reported Resident A is in memory care and the family expects caregivers to provide more one on one care than the facility can provide. Ms. Kiss reported the family has brought up false accusations of facility neglect. Ms. Kiss reported Resident A's family is not following the visitation policy by being rude to the receptionist, walking throughout the facility, and not wearing masks while inside the facility. Ms. Kiss was unable to provide any documentation on the issues with Resident A. Ms. Kiss reported the facility issued a discharge notice on 9/13.

Mr. Andriotti reported Resident A's family has been upset regarding visitation rules and have been rude to staff members. Mr. Andriotti reported Resident A's family has made accusations that Resident A is receiving improper care. Mr. Andriotti reported Resident A's family has been disruptive and the facility cannot handle the disruptive behavior of the family. Mr. Andriotti reported the facility is meeting Resident A's care needs, but the family does not feel they are. Mr. Andriotti reported the facility held a care conference with Resident A's family and the family was issued a discharge notice.

I reviewed the discharge notice for Resident A. The discharge notice read,

> *This letter serves as written communication to notify you of our intent to discharge you from Vista Springs Holland Meadows Community. This discharge notice is being given due to:*

Due to our inability to meet the needs of your family regarding COVID restrictions and family dissatisfaction of care provided.

We can no longer ensure the welfare and safety of you or other Community Members and we have no choice but to serve you this 30-day notice of discharge from the community. Please be advised that you must vacate the premises by 10/13/2021. Please note that you the right to file a complaint with the Department of Licensing and Regulatory Affairs.

Vista Springs Holland Meadows will assist you in locating an alternative living arrangement if needed. We will forward copies of medical records upon written request.

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(11) In accordance with MCL 333.20201(3)(e), a home's discharge policy shall specify that a home for the aged resident may be transferred or discharged for any of the following reasons: **(a) Medical reasons.** **(b) His or her welfare or that of other residents.** **(c) For nonpayment of his or her stay.** **(d) Transfer or discharge sought by resident or authorized representative.**
ANALYSIS:	On 9/13, Resident A was issued a 30-day discharge notice for dissatisfaction of care provided. The reason for discharge is not a valid reason under licensing rules.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A received inadequate care.

INVESTIGATION:

The complainant alleged on 9/5, they were able to visit Resident A in his room and he was found unattended in the shower. The complainant alleged Resident A's room was in disarray and had dirty linen on the bed.

Ms. Kiss reported Resident A believes he is independent and will try to complete care tasks by himself. Ms. Kiss reported Resident A is incontinent and at times will be found to have a bowel accident. Ms. Kiss reported Resident A makes his bed and at times caregivers believe there are clean sheets on the bed. Ms. Kiss reported Resident A tends to ambulate in the hallway with his walker. Ms. Kiss reported Resident A is to be checked on every hour. Ms. Kiss reported on 9/2, caregivers had just seen Resident A no more than 45 minutes prior to finding him in the shower. Ms. Kiss reported housekeeping checks and cleans Resident A's room at the beginning of their shift and at the end of their shift.

Ms. Fish reported Resident A believes he is independent and will attempt to complete tasks by himself. Ms. Fish reported Resident A is incontinent and will have bowel accidents. Ms. Fish reported caregivers check on Resident A every 30 minutes.

Ms. Arisp statements were consistent with those made by Ms. Kiss and Ms. Fish.

I reviewed Resident A's room. Resident A's room was neat and tidy as observed by the bathroom was clean, trash was taken out, and laundry was done. I observed Resident A's bed to appear to have been made but there was feces found on his blanket.

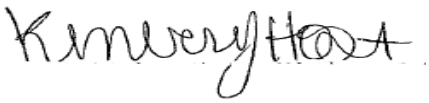
I reviewed the service plan for Resident A. The service plan read,

"provide assistance with bathing/showering. Provide assistance with toileting needs."

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.
ANALYSIS:	Interviews with management and employees revealed Resident A will attempt to complete self-care tasks independently, tends to have bowel accidents, and is on 30-minute checks. Review of Resident A's service plan omitted all this information and staff responsibility in ensuring the protection of Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

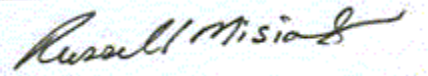
Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the status of the license.



9/22/21

Kimberly Horst Date
Licensing Staff

Approved By:



9/23/21

Russell B. Misiak Date
Area Manager