GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 19, 2021

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

RE: License #:	AH190401909
Investigation #:	2021A1021048
	Vista Springs Imperial Park 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 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 (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 #:	AH190401909
Investigation #:	2021A1021048
Complaint Receipt Date:	09/08/2021
Investigation Initiation Date:	09/09/2021
Report Due Date:	11/08/2021
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:	Keith Fisher
Authorized Representative:	Louis Andriotti, Jr.
Name of Facility:	Vista Springs Imperial Park at Timber Ridge
Facility Address:	16260 Park Lake Road East Lansing, MI 48823
Facility Telephone #:	(517) 339-2322
Original Issuance Date:	11/04/2020
License Status:	REGULAR
Effective Date:	05/04/2021
Expiration Date:	05/03/2022
Capacity:	40
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Insufficient staff at the facility.	Yes
Caregivers are not trained in medication administration.	Yes
Resident medications are not administrated.	Yes
Residents do not receive showers.	Yes
Additional Findings	Yes

III. METHODOLOGY

09/08/2021	Special Investigation Intake 2021A1021048
09/08/2021	APS Referral came from centralized intake at APS
09/09/2021	Special Investigation Initiated - Face to Face
09/10/2021	Contact - Document Sent email sent to administrator requesting documents. Admin asked for extension and it was granted
09/10/2021	Contact-Telephone call made Interviewed complainant 1
09/10/2021	Contact-telephone call made Interviewed complainant 2
09/14/2021	Contact - Face to Face Re-inspection completed and another request for documentation
09/15/2021	Contact-Telephone call made Interviewed caregiver Amber Stanton
09/17/2021	Contact-telephone call made Interviewed Careline Health Group practice manager Sheila Martin
09/17/2021	Contact-telephone call made

	Interviewed McLaren Greater Lansing - Mid-Michigan Physicians Internal Medicine Associates.
09/27/2021	Contact-Documents Received Received additional information on staffing from Keith Fisher
09/29/2021	Contact-Telephone call made Interviewed caregiver Maddison Pride
09/29/2021	Contact-Telephone call made Interviewed Interim Staffing Agency
09/30/2021	Contact-Telephone call made Interviewed Brightstar caregiver Niesha Lara
10/13/2021	Exit Conference Exit conference with authorized representative Lou Andriotti

ALLEGATION:

Insufficient staff at the facility.

INVESTIGATION:

On 9/8/21, the licensing department received multiple complaints with allegations the facility has a lack of staff to care for the residents. One complaint came from Adult Protective Services (APS).

On 9/9/21, I interviewed administrator Keith Fisher at the facility. Mr. Fisher reported lack of staff is an issue at the facility. Mr. Fisher reported the Vista Springs staffing matrix guidelines call for one caregiver and one medication technician for all shifts. Mr. Fisher reported the facility is working with staffing agencies, but the agencies do not always send people or do not have people to work. Mr. Fisher reported on 9/4 and 9/5, there were multiple staff that called in for their shifts. Mr. Fisher reported four of these staff members were terminated, other staff were provided verbal discipline, and all staff were re-educated on staff attendance. Mr. Fisher reported the facility attempted to contact other staff members to fill in the open shifts. Mr. Fisher reported there is no mandation policy in place at the facility that requires current staff to remain until replacements are found. Mr. Fisher reported the facility is currently recruiting as best as they can. Mr. Fisher reported has hired seven new caregivers in the month of September.

On 9/9/21, I interviewed Resident A at the facility. Resident A reported there is lack of staff. Resident A reported on the weekends, it is difficult to find staff in the building for assistance.

On 9/9/21, I interviewed wellness director Dia Melhotra at the facility. Ms. Melhotra reported on 9/4 and 9/5, there was lack of staff in the building due to staff members calling in for their shifts. Ms. Melhotra reported there are three residents that are a two person assist, five residents on oxygen, two residents with catheters, and six residents that are a fall risk.

On 9/10/21, I interviewed Complainant 1 by telephone. Complainant 1 alleged the facility has lack of staff to care for the residents as evidenced by residents miss medications and do not receive showers.

On 9/10/21, I interviewed Complainant 2 by telephone. Complainant 2 alleged the facility had lack of staff on 9/4 and 9/5.

On 9/14/21, I interviewed Resident F at the facility. Resident F reported staffing has gotten worse at the facility. Resident F reported it can take up to thirty minutes for staff assistance.

On 9/14/21, I interviewed Fatmata Swaray at the facility. Ms. Swaray reported staffing is bad at the facility because caregivers will call in and not show up for their shift. Ms. Swaray reported caregivers are to call management, but the policy is not very clear on who to contact. Ms. Swaray reported on 9/5 there was lack of staff in the building and residents missed medications.

On 9/15/21, I interviewed caregiver Amber Stanton by telephone. Ms. Stanton reported staffing has improved but there are still staff shortages. Ms. Stanton reported there are times when she is the only caregiver in the building on third shift. Ms. Stanton reported at times a medication technician from another building, and not a scheduled medication technician for the facility will come over to assist.

On 9/29/21, I interviewed medication technician Maddison Pride by telephone. Ms. Pride reported she was scheduled to work on 9/5 in Gardenside which is an AFC facility located on the campus of the HFA facility. Ms. Pride reported a caregiver came from Imperial Park because a resident needed a pain medication. Ms. Pride reported there was no medication technician for day shift. Ms. Pride reported she provided pain medication and a few other important medications to residents before she had to return to Gardenside. Ms. Pride reported residents reported to her that they had missed medications.

On 9/30/21, I interviewed Brightstar caregiver Niesha Lara by telephone. Ms. Lara reported she worked on 9/5 and was the only caregiver in the building. Ms. Lara reported she worked 7:00am-3:00pm. Ms. Lara reported there was one medication technician scheduled for the entire campus. Ms. Lara reported residents did not

receive their medications on this day because the medication technician did not have time to come to the building. Ms. Lara reported there are residents that are a two person assist transfer and because she was the only one working, they stayed in bed the entire day. Ms. Lara reported many residents refused food because they had not received their required medications. Ms. Lara reported she tried to provide the best care possible, but adequate care was not provided to the residents by the residents stayed in bed, did not receive meals, and showers were not completed. Ms. Lara reported facility caregivers called management multiple times and management reported they were on vacation and could not assist. Ms. Lara reported a family member, and a facility caregiver called the police department because they were concerned about resident safety. Ms. Lara reported management was called again but still did not address the staffing issue. Ms. Lara reported when she left the facility at 3:00pm, a caregiver from another building came to provide care. Ms. Lara reported there still was not a medication technician scheduled and residents did not receive their medications until 10:00pm.

Mr. Fisher confirmed the schedule I received by email on 9/15 was the as worked schedule for 9/4 and 9/5. Mr. Fisher reported all residents wear a pendent and the pendent reaches to other adult foster care buildings on the campus.

I reviewed resident service plans. Resident C and Resident G service plan revealed the residents were a two person assist with transfer and Resident C requires assistance with evacuation. Resident C, G, H, I, and J required staff assistance with administration of medications.

I reviewed the staff schedule for 9/5. The schedule revealed:
7:00am-3:00pm: Brightstar staffing
7:00am-7:00pm: Fatmata Swaray
11:00pm-7:00am: Amber Stanton

I reviewed time stamp record for Fatmata Swaray. The document revealed on 9/5, Ms. Swaray worked from 5:00pm-9:00pm.

I reviewed call light response times for 9/4-9/11. The document revealed the average wait time for a call light was 18 minutes. On 9/5, the average call light response time was 23 minutes.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(5) The home shall have adequate and sufficient staff on duty at all times who are awake, fully dressed, and capable of providing for resident needs consistent with the resident service plans.
ANALYSIS:	Resident C and Resident G are a two person assist yet on 9/5

	there was only one staff person scheduled to provide care. In addition, on 9/5, there were no medication technician scheduled for day shift which resulted in missed medications for the residents.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** For reference special investigation report (SIR) 2021A1021022 dated 3/10/21 corrective action plan (CAP) dated 3/25/21

ALLEGATION:

Caregivers are not trained in medication administration.

INVESTIGATION:

The complainant alleged medication technicians are not trained in administering medications.

I reviewed Resident A and D's medication administration record (MAR). The MAR revealed Iterim Staffing, a contracted staffing agency, administered medications.

I requested staff training records for the contracted employees and was not provided any documented evidence of facility training.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(6) The home shall establish and implement a staff training program based on the home's program statement, the residents service plans, and the needs of employees, such as any of the following: **(g) Medication administration, if applicable.**
ANALYSIS:	The facility was unable to provide any documentation that agency staff were trained on the facility's medication administration policies and procedures.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident medications are not administrated.

INVESTIGATION:

The complainant alleged the 9/4 medications were not given because the computer system was down. The complainant alleged on 9/5 the facility did not administer medications until late in the evening because there was no medication technician on shift. The complainant alleged multiple medications were missed.
Mr. Fisher reported there were missed medications at some point during the weekend of 9/4 - 9/5. Mr. Fisher reported staff called in for their shift and the facility had a difficult time filling the open shifts. Mr. Fisher reported he was unsure the number of residents that missed medications and the exact date the medications were missed.

Resident A reported the facility had no staff to administer medications and therefore she missed her medications. Resident A reported a resident or family member contacted the police because there were so upset about the missed medications.

On 9/9/21, I interviewed Resident D at the facility. Resident D reported she missed medications between 9/4-9/5. Resident D reported the facility did not have a staff person to administer the medications.

On 9/9/21, I interviewed Resident E at the facility. Resident E reported she did not get her medications for a few days because the facility did not have a medication technician to administer the medications.

I reviewed the medication administration record (MAR) for Resident A and Resident D. The MAR revealed on 9/4, residents received their medications by Emily Martinez, Teresa Plank, and Interim Staffing. There was no documentation that residents did not receive their medications.

I attempted to contact Emily Martinez and Teresa Plank multiple times with no response.

I reviewed the MAR for Resident A and D. The MAR revealed on 9/5, the residents only received medications at 6:00pm.

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:	Interviews with management, staff members, and residents revealed on 9/5 there was no medication technician in the building and residents did not receive medications. Review of Resident A and Resident D's MAR revealed on 9/5, the

	residents did not receive medications until 6:00pm even though there were medications scheduled for 8:00am, 12:00pm, and 5:00pm. The resident medications were not administered according to the licensed health care professional.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Residents do not receive showers.

INVESTIGATION:

The complainant 1 alleged Resident A has gone eight days without a shower. Complainant 1 alleged she has had to shower Resident A because staff are not available to shower Resident A.

Resident A reported staff do not have the time to shower her. Resident A reported she has gone multiple days without a shower.

Ms. Melhotra reported the facility has a shower schedule for each resident to receive two showers a week. Ms. Melhotra reported caregivers are to document each time a resident receives a shower.

On 9/14/21, I interviewed caregiver Mari Lopez at the facility. Ms. Lopez reported residents are to receive two showers a week. Ms. Lopez reported caregivers are to document when a shower is given.

I requested shower documentation for Resident A. The facility had no documentation of showering Resident A.

APPLICABLE RULE	
R 325.1933	**Personal care of residents.**
	(2) A home shall afford a resident the opportunity and instructions when necessary for daily bathing, oral and personal hygiene, daily shaving, and hand washing before meals. A home shall ensure that a resident bathes at least weekly and more often if necessary.
ANALYSIS:	Resident A conveyed that due to a lack of adequate staffing she does not always receive a shower. The facility trains and expects that their staff will document the provision of showers. The facility could not provide documentation that established

	Resident A received a shower. Given these two facts, the facility has not complied with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Observations made at the facility revealed Resident B had a halo ring attached to her bed. In addition, Resident C had a ½ bedrail attached to her bed. Both devices were mechanically sound and were firmly attached to the bed. The mattress was not able to slide away from the device. The devices bar openings were small enough so that the resident could not become entrapped.

I reviewed Resident B and C's service plan. Within the service plan, there was no use and purpose descriptions of the assistive devices. There was no physician order for the devices and no consent form within the resident record.

On 9/29/21, I interviewed caregiver Maddison Pride by telephone. Ms. Pride reported there is one resident with a bedside assistive device. Ms. Pride reported the device is used to assist with bed mobility. Ms. Pride reported staff have no responsibilities with the device.

Mr. Fisher reported halo devices are allowed at the facility. Mr. Fisher provided the following policy on the halo devices:

> *It is the POLICY of Vista Springs' to allow Halo Rails for Community Members with a physician order in the event an assessment of Community Member identifies the need for assistance with bed mobility/transfers.*
>
> ***PROCEDURE**:*
> *1. A Community Member or legal representative shall complete a Halo Rail Consent form (VS 352-1) and submit to the Health and Wellness Director.*
>
> *2. The Community Member Halo Rail Consent form requesting a Halo Rail will be reviewed and discussed with the Community Member's physician.*
>
> *3. A Physician's order will be written and submitted to the Durable Medical Equipment (DME) Company of Community Member's choice if deemed appropriate by the physician.*

4. The DME will deliver and install the Halo Rails prescribed and provide education to the Community Member and designee for safe use. The manufacturer's instructions will be placed in the Community Member's chart.

5. The Halo Rail o will be inspected on a monthly basis by the Health and Wellness Director or designee. All measurements to ensure compliance with the latest FDA guidelines will also be done on a monthly basis:
The Halo rail is mechanically sound, firmly attached to the bed frame, and any latches or mechanics are in good working order.
The distance between the slats (the horizontal or vertical supports between the perimeters of the rail itself) or the Halo bed rail is small enough to prevent the resident from becoming entrapped between the slats.
Any space between bed rail or device and mattress and between mattress and head or footboard shall be eliminated with the use of foam wedges.
When the bed is occupied, the top surface of the mattress shall be higher than the bottom of the Halo rail.
Hazards created by improperly installed or positioned bed rails or devices include:

A gap created if the mattress or mattress pad is ill-fitted or out of position. The resident may become asphyxiated if the resident slips into the gap with their face pressed against the mattress and is unable to extricate by self.
Entrapment when a resident's head becomes lodged between the mattress and the bed rails or bedside assistive device resulting in compression of the resident's neck and throat.
Entrapment when a person is trapped in the space between the mattress and headboard, mattress and footboard or a resident slides out of bed and becomes trapped between the Halo rail or device and the bed frame. Risk of
serious injury or death when the resident's size and/or weight are inappropriate to the bed's capacity or dimensions.

6. The use of the Halo rail shall be included in the service plan and include the frequency of resident observation when in use.

7. Ongoing assessment for the continuing safety and use of the Halo Rail will be performed during each scheduled assessment or in change of clinical/functional status of the Community member.

APPLICABLE RULE	
R 325.1921	**Admission and retention of residents.**
	(1) The owner, operator, and governing body of a home shall do all of the following:

	(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.
For Reference: R 325.1901	**Definitions.**
	(16) "Protection" means the continual responsibility of the home to take reasonable action to ensure the health, safety, and well-being of a resident as indicated in the resident's service plan, including protection from physical harm, humiliation, intimidation, and social, moral, financial, and personal exploitation while on the premises, while under the supervision of the home or an agent or employee of the home, or when the resident's service plan states that the resident needs continuous supervision.
ANALYSIS:	Resident B and Resident C's bed were each outfitted with a beside assistive device. The facility has a bedside assistive device policy with procedures to ensure their safe use within the facility. The facility policy expressly reads that bedrails are not allowed. However, inspection found that Resident C had a ½ bedrail attached to her bed. Review of Resident B and Resident C's records revealed the policy was not followed as evidence by lack of consent form, physician order, and required information documented within their service plans.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **For reference SIR 2021A1021022 dated 3/10/21 CAP dated 3/25/21**

INVESTIGATION:

At the time of my investigation, I requested Resident A's service plan. Resident A was admitted to the facility on 7/23/21. Ms. Melhotra reported the facility did not complete a service plan at time of admission and did not have a service plan on file.

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(2) The admission policy shall specify all of the following:

	(c) That the individual seeking admission and his or her authorized representative, if any, shall participate in the development of the individual's service plan.
ANALYSIS:	The facility did not complete a service plan that identified the specific care for Resident A's physical, social, and behavioral needs and well-being.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

Review of employee files revealed multiple employees were missing required staff training. The following observations were noted:

Michael Allen was hired on 12/17/20 and employee record had no staff training documents.

Brooke Bauer was hired on 7/30/21 and had no record of resident rights and responsibilities training.

Jessica Kalka was hired on 12/30/20 and employee record had no documentation of reporting requirements, program statement, service plan, and resident rights and responsibilities training.

In addition, Mr. Fisher reported the facility is using multiple staff agencies for staff shortages. Mr. Fisher reported the facility does not complete any training on site for these caregivers.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	6) The home shall establish and implement a staff training program based on the home's program statement, the residents service plans, and the needs of employees, such as any of the following: **(a) Reporting requirements and documentation.** **(b) First aid and/or medication, if any.** **(c) Personal care.** **(d) Resident rights and responsibilities.** **(e) Safety and fire prevention.** **(f) Containment of infectious disease and standard precautions**

ANALYSIS:	Review of employee records revealed the facility is not implementing a staff training program to ensure caregivers are trained in required areas.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **For reference Licensing study report (LSR) AH190401909_RNWL_20210412 CAP dated 5/3/21.**

INVESTIGATION:

Review of Resident A, D and E's August and September MAR revealed multiple instances of no "initials" that would have confirmed that medication was administered as prescribed.

APPLICABLE RULE	
R 325.1932	**Resident Medications.**
	(3) If a home or the home's administrator or direct care staff member supervises the taking of medication by a resident, then the home shall comply with all of the following provisions: **(b) Complete an individual medication log that contains all of the following information:** **(v) The initials of the person who administered the medication, which shall be entered at the time the medication is given.**
ANALYSIS:	Review of multiple resident MAR's for multiple months revealed the facility does not have a complete and thorough medication log demonstrating who administered or if medications were administered.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

Mr. Fisher reported after the missed medications on 9/5, resident's licensed health care professionals were made aware. Mr. Fisher reported all the residents are on service with Careline Health Group.

On 9/17/21, I interviewed Careline Health Group practice manager Sheila Martin by telephone. Ms. Martin reported they do not have the entire facility on their service. Ms. Martin reported Resident A is on their service, but Resident D and E are not on their service. Ms. Martin reported if a resident misses their medication the physician needs to be notified to adjust the resident's plan of care. Ms. Martin reported the office was not notified of any missed medications.

On 9/17/21, I interviewed McLaren Greater Lansing - Mid-Michigan Physicians Internal Medicine Associates. The office confirmed Resident D is on their service. The office confirmed they did not receive notification of missed medications.

APPLICABLE RULE	
R 325.1932	**Resident Medications.**
	(3) If a home or the home's administrator or direct care staff member supervises the taking of medication by a resident, then the home shall comply with all of the following provisions: **(g) Upon discovery, contact the resident's licensed health care professional if a medication error occurs. A medication error occurs when a medication has not been given as prescribed.**
ANALYSIS:	The facility did not appropriately contact each resident's licensed health care professional after the missed medications.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

I was provided a schedule for 9/4 and 9/5. The schedule showed the following employees worked:

9/4: 7:00am-1:00pm: Interim Staffing

9/5: 7:00am-3:00pm: Brightstar staffing
7:00am-7:00pm: Fatmata Swaray, medication technician
11:00pm-7:00am: Amber Stanton

The resident MAR's I reviewed for 9/5 had Interim Staffing and Natasha Spagnouolo initials as administering medications.

Review of the time stamp for 9/5 for Fatmata Swaray revealed Ms. Swaray worked 5:00pm-9:00pm.

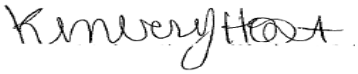
On 9/29/21, I contacted Interim Staffing Agency. The agency reported on 9/4, they provided caregiver Samantha Opperman at 6:45pm and Camiah Dear at 11:00pm.

APPLICABLE RULE	
R 325.1944	**Employee records and work schedules.**
	(2) The home shall prepare a work schedule showing the number and type of personnel scheduled to be on duty on a daily basis. The home shall make changes to the planned work schedule to show the staff who actually worked.
ANALYSIS:	The facility did not make changes to the work schedule to show who actually worked. On 9/4, interim staffing provided caregivers at 6:45pm and 11:00pm not 7:00am. In addition, on 9/5, Ms. Swaray worked at 5:00pm not 7:00am as showed on the schedule.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 10/13/21, I completed an exit conference with authorized representative Louis Andriotti, Jr. by telephone. Mr. Andriotti reported 9/5 was a very difficult day for the facility regarding staffing. Mr. Andriotti reported the facility attempted to find staff and was not successful. Mr. Andriotti reported since 9/5, the facility has made significant improvements in staffing and has completed chart audits. Mr. Andriotti reported the facility has hired additional staff and nurses. Mr. Andriotti reported Mr. Fisher has held family meetings with resident family members to address the issues at the facility. Mr. Andriotti reported the facility has already addressed and will continue to address the violations in this report.

IV. RECOMMENDATION

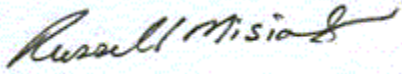
Upon receipt of an acceptable corrective action plan, I recommend no change in the status of the license.



10/12/21

Kimberly Horst — Date
Licensing Staff

Approved By:



10/12/21

Russell B. Misiak — Date
Area Manager