GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 10, 2021

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

RE: License #: AH410400149
Investigation #: 2022A1010004
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 N.W. Unit 13 7th Floor
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 #:	2022A1010004
Complaint Receipt Date:	10/14/2021
Investigation Initiation Date:	10/14/2021
Report Due Date:	12/13/2021
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:	09/04/2021
Expiration Date:	09/03/2022
Capacity:	56
Program Type:	ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
The "sharps" container on the medication cart is full.	Yes
• Resident A's wounds are not being treated. • Residents in the facility are left soiled for long periods of time.	Yes

III. METHODOLOGY

10/14/2021	Special Investigation Intake 2022A1010004
10/14/2021	Special Investigation Initiated - Telephone Interviewed the complainant by telephone
10/21/2021	Inspection Completed On-site
10/21/2021	Contact - Document Received Received resident service plan, hospice orders, and staff notes
10/21/2021	Contact - Face to Face Interviewed hospice nurse at the facility
11/09/2021	Contact – Document Received Faith Hospice nurse notes received via fax
12/10/2021	Exit Conference Completed with licensee authorized representative Lou Andriotti

ALLEGATION:

The "sharps" container on the medication cart is full.

INVESTIGATION:

On 10/14/21, I received a telephone call from the complainant. I interviewed the complainant by telephone. The complainant reported the "sharps container" on the medication cart is often left full. The complainant stated this was reported to the facility's health and wellness director, however this continues to be an issue.

On 10/21/21, I interviewed the facility's managing partner Kim Vagnetti at the facility. Ms. Vagnetti denied knowledge regarding the "sharps" container being left full on the medication carts. Ms. Vagnetti reported she was new to her position, therefore she had no additional information.

On 10/21/21, I interviewed the facility's health and wellness director Barb Cox at the facility. Ms. Cox reported staff were trained to remove the "sharps" container off the medication carts when they are full. Ms. Cox explained staff were trained to remove the full container off the cart with the required key. Ms. Cox stated the full container is then placed in a secured storage room until the facility's contracted medical supply company picks the full containers up. Ms. Cox said after the full container is removed, an empty container is put on the cart.

On 10/21/21, I interviewed medication technician (med tech) Shauna Meengs at the facility. Ms. Meengs reported she was told to contact the wellness director when the "sharps container" is full on the medication carts. Ms. Meengs stated the wellness director then removes the full container and is supposed to replace it with an empty one. Ms. Meengs said she did not receive training regarding what to do when the "sharps" container is full during her medication administration training.

On 10/21/21, I observed the "sharps" container was full on one of the secured medication carts that was in a common area. I observed the container was almost overflowing onto the floor. I was able to reach my hand inside the container and could have removed items within. There were used needles and other hazardous items within the container. When I observed the full sharps container, there were several residents sitting near the cart. I observed staff were in and out of resident rooms, leaving the residents unsupervised with the medication cart nearby.

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	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.**
ANALYSIS:	The interviews with Ms. Cox and Ms. Meengs revealed the facility does not provide proper training to staff regarding how to manage a full "sharps" container on medication carts. Ms. Cox and Ms. Meengs gave contradictory statements regarding how full "sharps" containers are to be handled in the facility and who is responsible for handling them. I observed a full "sharps" container on a medication cart within reach of residents. The facility is a secured memory care unit for residents with poor

	safety awareness. Allowing residents with poor safety awareness to have access to used needles is not consistent with an organized program of protection.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

- **Resident A's wounds are not being treated.**
- **Residents in the facility are left soiled for long periods of time.**

INVESTIGATION:

On 10/14/21, The complainant reported Resident A has an ulcer on her spine that is not being treated by staff at the facility. The complainant stated there was one instance when the dressing on Resident A's wound was not changed for two days. The complainant reported Resident A's wound had a foul odor because of inadequate care. The complainant said the medication technicians (med techs) are supposed to change Resident A's dressing daily, however it is not being done.

The complainant stated Resident A received hospice services. The complainant reported hospice staff were in to assist Resident A with bathing and other activities of daily living (ADLs) Monday through Wednesday during the week.

On 10/21/21, Ms. Vagnetti reported she was not yet familiar with Resident A's service plan due to being new in her position at the facility.

On 10/21/21, Ms. Cox stated resident A's wound was discovered by staff this week. Ms. Cox said hospice staff were responsible for changing the dressing on Resident A's wound. Ms. Cox reported Resident A passed away this morning and hospice staff were onsite. Ms. Cox stated Resident A's hospice nurse was in to see Resident A once a week and a hospice aide was in twice a week.

Ms. Cox denied knowledge regarding residents being left soiled. Ms. Cox reported she had not received any complaints from residents or resident family members regarding residents being left soiled. Ms. Cox said staff were trained to change a resident's soiled brief as needed and upon its discovery.
On 10/21/21, Ms. Meengs reported Resident A's wounds were treated by care staff at the facility. Ms. Meengs stated Resident A's wounds had a foul odor, however to her knowledge the dressings were changed every day. Ms. Meengs said hospice staff ordered the dressings for Resident A's wounds.

Ms. Meengs stated staff were trained to check on residents every two hours. Ms. Meengs reported if a resident was found incontinent before they were checked every

two hours, staff were trained to change them upon discovery. Ms. Meengs denied knowledge regarding residents being intentionally left soiled by staff.

On 10/21/21, I interviewed Faith Hospice nurse Kaila DeGroot at the facility. Ms. DeGroot reported Resident A had wounds on her back and on her heels. Ms. DeGroot stated hospice ordered heel protectors and for staff to elevate resident A's ankles. Ms. DeGroot said after some miscommunication from the facility, it was determined care staff were to change the dressings on Resident A's wounds daily.

Ms. DeGroot reported staff at the facility did not follow hospice orders regarding Resident A's wound care treatment. Ms. DeGroot stated there were several incidents when she arrived at the facility to see Resident A and her heel protectors were not on and her ankles were not elevated. Ms. DeGroot said it was also evident staff were not changing the dressings on Resident A's wounds. Ms. DeGroot explained Resident A's wounds worsened and had foul odors. Ms. DeGroot reported there was continual "drainage" from Resident A's wounds.

On 10/21/21, I was unable to interview or observe Resident A because she was deceased.

On 10/21/21, I observed several residents in the common areas of the facility. The residents were appropriately dressed and well groomed. I did not detect any foul odors in the facility.

On 10/21/21, the facility's administrator Jennifer Slater provided me with a copy of Resident A's service plan for my review. The *TOILETING* section of the plan read, "Provide assistance with toileting needs including peri care after toileting. Check on resident every two hours to be sure she is clean and dry." The *FREQUENT ROUNDING* section of the plan read, "Staff to frequently round on community member through out shift. This includes passing snack or water, tidying up room, assisting to an activity, completeting [sic] ADLs and when called as needed from call pendant. Wellness checks through night shift. Staff are to initial each shift that rounding was completed." The *HOSPICE PROVIDER* section of the plan read, "Faith Hospice."

Ms. Slater provided me with a copy of Resident A's staff notes for my review. A note dated 10/12 read, "Hospice was called due to CM back sore looks and smells horrible MTP's make sure we are changing bandage everyday [sic]. Case manager will be here tomorrow to take a look at it." Ms. Slater also provided me with a copy of Resident A's Faith Hospice orders for my review. An order dated 9/20 read, "Daily dressing changes to spine. Clean with wound cleanser, apply Telfa Pad (non adherent) to wound cover with ABD pad and secure with tape. APM mattress ordered from Carelinc spoke with Dawn will be delivered today or tomorrow morning. Apply 3x3 mepilex to coccyx. Change every 5 days." An order dated 10/6 read, "New wounds to left and right heel. Heel protector boots ordered. Patient to wear boots at all times. Apply mepilex border to left and right heel wounds every 3 days or as

needed by facility. An order dated 10/11 read, “1.) Keflex 500mg 1 tablet daily BID x 7 days. Ok to crush. 2.) Flagyl 50mg tablet crush and apply directly to spinal wound daily with dressing changes by facility.”

On 11/9/21, I received the Faith Hospice *NARRATIVE NOTES* via fax. A note dated 9/26 read, “Focused visit to follow up on patients wound to spine. Monti, Med tech states that there are no dressing changes for patient. RNCM explained that written orders were given to med tech Ka’Maria on Monday and supplies for dressing changes came yesterday per phone call RNCM received from Ka’Maria. Wound supplies found in patients bathroom. Pressure sore appears to be a Kennedy Ulcer. Dressing changed with help from med tech. Education provided on daily dressing changes and frequent turning of patient while in bed.”

A note dated 10/13 read, “Patient spinal wound has copious amounts of foul smelling brown drainage coming from wound. Dressing changed and patient tolerated well. Facility had not been changing wound daily because ‘the orders were not in the computer’. RN and Jill spoke with Barb facility wellness coordinator on Friday who verified that staff are able to do dressing changes and orders were placed in their computer system.”

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:	The interviews with Faith Hospice nurse Ms. DeGroot, along with review of the Faith Hospice *NARRATIVE NOTES* revealed there were instances when Resident A’s wounds were not properly treated by staff at the facility. Ms. Cox and Ms. Meengs’ statements regarding who was responsible for Resident A’s wound care were contradictory. Review of Resident A’s service plan revealed who was responsible for Resident A’s wound care was not outlined. I observed several residents in common areas of the facility. The residents were appropriately dressed and well groomed. I did not detect any foul odors in the facility. There is insufficient evidence to suggest residents are intentionally left soiled for long periods of time.
CONCLUSION:	**VIOLATION ESTABLISHED**

I shared the findings of this report with licensee authorized representative Lou Andriotti by telephone on 12/10. Mr. Andriotti stated he has spent approximately one month at the facility addressing staffing issues, including work performance. Mr. Andriotti reported the corrective measures that have been put in place will be included in the corrective action plan.

IV. RECOMMENDATION

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

11/9/21

Lauren Wohlfert — Date
Licensing Staff

Approved By:

12/10/21

Russell B. Misiak — Date
Area Manager