GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 8, 2022

Louis Andriotti, Jr.
Vista Springs Riverside Gardens LLC
Ste 110
2610 Horizon Dr. SE
Grand Rapids, MI 49546

RE: License #: AH410397993
Investigation #: 2022A1028021
Vista Springs Riverside Gardens

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 I am not available, and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,
Julie Viviano, Licensing Staff
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
Cell (616) 204-4300

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

I. IDENTIFYING INFORMATION

License #:	AH410397993
Investigation #:	2022A1028021
Complaint Receipt Date:	12/20/2021
Investigation Initiation Date:	12/22/2021
Report Due Date:	03/19/2022
Licensee Name:	Vista Springs Riverside Gardens LLC
Licensee Address:	Ste 110 2610 Horizon Dr. SE Grand Rapids, MI 49546
Licensee Telephone #:	(616) 259-8659
Administrator:	Susan Alveshere
Authorized Representative:	Louis Andriotti
Name of Facility:	Vista Springs Riverside Gardens
Facility Address:	2420 Coit Ave. NE Grand Rapids, MI 49505
Facility Telephone #:	(616) 365-5564
Original Issuance Date:	07/22/2020
License **Status:**	REGULAR
Effective Date:	01/22/2022
Expiration Date:	01/21/2023
Capacity:	70
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Physician orders for Resident A for insulin management were not followed in accordance with the service plan.	Yes
Additional Findings	Yes

III. METHODOLOGY

12/20/2021	Special Investigation Intake 2022A1028021
12/22/2021	Special Investigation Initiated - Letter APS referral emailed to Centralized Intake
12/22/2021	APS Referral APS referral emailed to Centralized Intake
01/24/2022	Contact - Telephone call made Interviewed the complainant by telephone
01/31/2022	Contact - Face to Face Interviewed Assoc. Admin, Tasha Hall, at facility
01/31/2022	Contact - Face to Face Interviewed Wellness Director, Vicki Dean, at the facility
01/31/2022	Contact - Face to Face Interviewed care staff Tracy Scheuneman at the facility
01/31/2022	Contact - Face to Face Interviewed care staff, Kathy Andrews, at the facility
01/31/2022	Contact - Telephone call made Interviewed care staff supervisor, Jennifer Stanley, at the facility
03/08/2022	Exit Interview

ALLEGATION:

Physician orders for Resident A were not followed in accordance with the service plan.

INVESTIGATION:

On 12/21/21, the Bureau received the allegations through the online complaint system.

On 1/24/22, I interviewed the complainant by telephone. The complainant reported the facility did not administer Resident A's insulin accordingly throughout Resident A's stay at the facility. Resident A was to receive three units of insulin with every meal plus a sliding scale. The complainant reported the facility ensured understanding of this order upon Resident A's admission but was unable to demonstrate correct insulin administration. The complainant also reported Resident A received poor wound management as well following a 9/30/21 procedure and discharge instructions were not followed. Resident A's bandage from the catheter removal was fused to the skin and never cleaned. The complainant reported multiple care conferences concerning Resident A's care were completed, but Resident A was not provided the care agreed upon. The complainant provided me documentation for my review.

On 1/31/22, I completed an onsite inspection of the facility. The facility was clean, and residents observed were content and well groomed. The inspection also revealed Resident A had moved from the facility that morning.

On 1/31/22, I interviewed associate administrator, Tasha Hall, at the facility. Ms. Hall reported Resident A was to receive three units of insulin with every meal plus a sliding scale. Ms. Hall reported the facility had multiple care conferences with the authorized representative and family concerning Resident A's care. Ms. Hall reported Resident A did receive the correct insulin administration, but it was discovered care staff only recorded the sliding scale amount in the medication administration record (MAR) and did not include the base unit amount of three units. Ms. Hall reported it was a documentation error and not a medication administration error. Ms. Hall reported all med technicians were conferenced with and re-educated on correct documentation for Resident A's base unit plus the sliding scale. Ms. Hall also reported care orders for the discharge procedure care on 9/30/21 were followed. Ms. Hall provided me a copy of Resident A's service plan and MAR with record notes and physician orders from September 2021 to January 2022 for my review.

On 1/31/22, I interviewed wellness director, Vicki Dean, at the facility. Ms. Dean reported Resident A had a history of refusing care and demonstrated behaviors towards staff during care routines and even to other residents throughout the stay at the facility. Despite, refusal of care, Ms. Dean reported discharge care for Resident

A’s procedure on 9/30/21 was followed accordingly by care staff. Ms. Dean reported family was notified of refusals of care and several care conferences were completed with the authorized representative and family to “keep an open of communication about [Resident A’s] care”. Ms. Dean reported Resident A was to receive three base units of insulin with every meal plus a sliding scale. Ms. Dean reported it was discovered that while care staff were administering the correct dosage, it was not documented correctly in the MAR. Care staff were only documenting the sliding scale and not including the base unit measure “because the base unit was already written in the record”. Ms. Dean also reported care staff coordinator, Jennifer Stanley, completed an internal investigation to ensure Resident A received the correct insulin dosage. The internal investigation revealed it was a documentation error, not a medication administration error. Staff were re-educated on correct documentation to ensure compliance.

1/31/22, I interviewed care staff, Tracy Schewneman, at the facility. Ms. Schewneman reported Resident A would refuse care from staff and could be “quite verbally aggressive, cussing at staff and other residents”. Ms. Schewneman reported it could be difficult to provide Resident A care at times due to the behaviors and consistent refusals. Ms. Schewneman reported knowledge of several care conferences between the facility and Resident A’s authorized representative and family to address concerns due to the refusals of care and behaviors. Ms. Schewneman explained Resident A’s baseline measure was three units of insulin plus a sliding scale. Ms. Schewneman reported to her knowledge there were no issues with medication administration for Resident A, but it was not documented correctly. Ms. Schewneman reported care staff thought only the sliding scale was to be documented because the baseline was standard in the MAR. Ms. Schewneman reported once the documentation error was discovered, all med technicians were re-trained and re-educated on correct documentation protocol and “there weren’t any issues since”.

1/31/22, I interviewed care staff, Kathy Andrews, at the facility. Ms. Andrews was able to explain the correct insulin administration for Resident A but reported there was a discovered documentation issue with the recording of the sliding scale in the MAR. Ms. Andrews reported all med technicians immediately received re-education on correct documentation and an internal investigation was completed to ensure Resident A received the correct medication dosage. Ms. Andrews also reported Resident A demonstrated behaviors towards staff and other residents and “could be quite mean”. Ms. Andrews confirmed Resident A’s history of refusing care.

On 1/31/22, I interviewed care staff coordinator, Jennifer Stanley, by telephone. Ms. Stanley reported Resident A had a history of care refusal despite staff efforts. Care conferences were completed between Resident A’s authorized and family with the facility to address Resident A’s behaviors and care concerns since Resident A’s admission to the facility in September 2021. Psychiatric nursing services were

recommended to the family and authorized representative and ordered to address Resident A's behaviors. Ms. Stanley reported there was a documentation issue in which care staff "thought they only needed to document the sliding scale for [Resident A's] insulin because the base line of three units was already written in the MAR". Ms. Stanley reported she completed an internal investigation once it was discovered care staff were documenting incorrectly. Ms. Stanley reported the internal investigation revealed Resident A received the correct insulin dosage, but care staff did not record the base unit with the sliding scale correctly. Ms. Stanley reported she re-educated all med technicians about recording documentation correctly and there have been no documentation issues since. Ms. Stanley also reported the department was notified of the facility internal investigation. Ms. Stanley was unable to provide evidence of staff re-education, stating she "met with each med tech individually on all shifts to conference with them about documenting the base units with the sliding correctly".

On 2/3/22, I reviewed Resident A's service plan which revealed Resident A required one to two person assist for bathing, dressing, grooming, personal hygiene, oral care, toileting, all transfers and wheelchair mobility. Resident A's medication administration was managed by the facility to include pressure ulcer management. Resident A also had weekly dialysis outside of the facility on Tuesdays, Thursdays, and Saturdays.

I also reviewed Resident A's MAR from September 2021 to January 2022 with record notes which read:

- *Resident A was to receive an injection of three units of Humalog plus give the units needed base on sliding scale to equal the total units.*
  100-149 = 0 units 150-199 = 1 unit 200-249 = 2 units
  25-299 = 3 units 300-349 = 4 units 350-399 = 5 units
  400-449 = 6 units anything higher contact Dr. Hunt

The review also revealed October's 2021 MAR for Resident A's sliding scale was not documented correctly. The November 2021 MAR contained sliding scale documentation errors on 11/5, 11/7, 11/11, 11/14, 11/16, 11/21, and 11/28. The December 2021 MAR contained sliding scale documentation errors on 12/4, 12/9, 12/14, 12/17, 12/18, 12/20, 12/21, 12/23, 12/24, 12/25, 12/27, 12/29, and 12/31. The December MAR contained sliding scales errors on 1/22, and 1/23.

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:** **i. The medication.** **ii. The dosage.** **iii. Label instructions for use.** **iv. Time to be administered.** **v. The initials of the person who administered the medication, which shall be entered at the time the medication is given.** **vi. A resident's refusal to accept prescribed medication or procedures.**
ANALYSIS:	Per physician orders, Resident A was to receive a baseline of three units of insulin with a sliding scale with meals. Interviews revealed care staff demonstrated competency of Resident A's insulin management but did not correctly document the insulin management within Resident A's MAR. Despite the facility reporting re-training was provided, care staff were unable to demonstrate competency of correct documentation of Resident A's insulin management. Review of Resident A's MAR from September 2021 to January 2022 revealed significant and continued medication administration documentation errors.
CONCLUSION:	**VIOLATION ESTABLISHED**

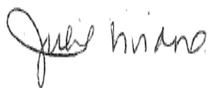
Additional Findings:

On 2/3/22, I reviewed Resident A's January 2022 MAR which revealed on 1/27/22, Resident A's blood sugar was documented at 504 at 5:38pm in the MAR and Resident A was given 9 units of insulin accordingly. However, the physician order states if Resident A's blood sugar level is higher than 449, Dr. Hunt is to be contacted. There is no evidence that Dr. Hunt was contacted about Resident A's elevated blood sugar level.

APPLICABLE RULE	
R 325.1921(1)	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following: **(c) Assure the availability of emergency medical care required by a resident.**
ANALYSIS:	Per physician orders, Resident A was to receive a baseline of three units of insulin with a sliding scale. If Resident A's blood sugar level was elevated greater than 449, Resident A's physician was to be contacted. On 1/27/22, Resident A demonstrated an elevated blood sugar level of 504 and was administered 9 units of insulin accordingly. However, there is no evidence that facility care staff contacted Resident A physician. The facility did not follow physician orders potentially placing Resident at great harm or risk of injury.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an approved corrective action, I recommend the status of this license remain the same.



2/3/22

Julie Viviano Date
Licensing Staff

Approved By:

02/24/2022

Andrea L. Moore, Manager Date
Long-Term-Care State Licensing Section