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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 9, 2022

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

RE: License #: AH410400149
Investigation #: 2022A1010020
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 NW 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 #:	2022A1010020
Complaint Receipt Date:	01/18/2022
Investigation Initiation Date:	01/19/2022
Report Due Date:	03/17/2022
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, Jr.
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?
Staff Person A got into an altercation with Resident C.	Yes

III. METHODOLOGY

01/18/2022	Special Investigation Intake 2022A1010020
01/19/2022	Special Investigation Initiated - Letter Email received from AR Lou Andriotti, employee was terminated after the incident
01/27/2022	Inspection Completed On-site
01/27/2022	Contact - Document Received Received Resident C's service plan
01/31/2022	Contact – Telephone call made I interviewed staff person Grayson Cooper by telephone
02/01/2022	Contact – Document Received Received Staff Person A's resident rights training documents
03/09/2022	Exit Conference Completed with licensee authorized representative Lou Andriotti

ALLEGATION:

Staff Person A got into an altercation with Resident C.

INVESTIGATION:

On 1/18/2022, the Bureau received the complaint from Adult Protective Services (APS). The complaint was not assigned for APS investigation. The complaint read, "On 01/14/2022, there was an incident between an employee [Staff Person A] and [Resident C]. [staff person] was screaming and yelling at [Resident C]. [Staff Person A] was holding [Resident C] by her wrist in her wheelchair leaving her wrist red. [Staff Person A] was terminated by Vista Springs Northview. [Resident C] suffers from: dementia, hypertension, hypothyroidism, and fall risk."

On 1/19/2022, I re-reviewed an email I received from licensee authorized representative Lou Andriotti on 1/16/2022. Mr. Andriotti provided an incident report regarding the incident between [Staff Person A] and Resident C on 1/14. Mr.

Andriotti stated [Staff Person A] was terminated and the staff person who witnessed the incident responded and intervened appropriately.

The *Narrative description of facts of incident – Include cause, if known* section of the report read, “Medication Treatment Professional, Grayson Cooper, heard loud yelling from common area, while on the phone with the Wellness Director, Stacey Rowe. Grayson noted that in common area Medication Treatment Professional, [Staff Person A], was yelling at a dementia resident to sit in her chair. [Staff Person A] continued to yell at resident and tell resident she did not belong at facility. Personal Wellness Partner, Kassandra Morgan witnessed [Staff Person A] grab wrists of resident in attempt to forcibly put her in a chair. Grayson then approached altercation and removed resident from area for safety and to provide compassionate care and kind sensitivity to calm her agitation.”

The *Corrective measures taken to prevent recurrence of this incident* section of the report read, “Medication Treatment Professional, [Staff Person A] was terminated immediately during her shift due to inappropriate behavior with resident. [Staff Person A] was watched leaving the facility. She left in a fit of anger, threatening, yelling, saying she quit, and berating staff. Residential Services Director was called int to change all entry/exit door lock codes.”

On 1/27/2022, I interviewed Ms. Rowe at the facility. Ms. Rowe reported Ms. Cooper was on the telephone with her during the incident on 1/14/2022. Ms. Rowe stated she could hear yelling in the background while she was on the telephone with Ms. Cooper. Ms. Rowe’s statements were consistent with the incident report that Mr. Andriotti submitted.

Ms. Rowe said she received a picture of red marks on Resident C’s wrists that were present after the Staff Person A attempted to hold Resident C down in her wheelchair during the incident. Ms. Rowe reported she received the picture via text message from Ms. Cooper. Ms. Rowe stated the red marks on Resident C’s wrist faded quickly after the incident. Ms. Rowe said due to Resident C’s memory loss, she cannot recall the incident.

Ms. Rowe reported the Staff Person A received written reprimands in the past regarding how she communicated with other staff persons. Ms. Rowe stated the Staff Person A never received a written reprimand in the past regarding how she cared for or spoke to residents.

Ms. Rowe provided me with a copy of Resident C’s service plan for my review. The *INCREASED ANXIETY* section of the plan read, “Community member may become anxious at times. Staff to: 1. Decrease stimuli 2. Encourage to do household task such as fold laundry or gather trash in common areas 3. Offer coffee 4. Give Ativan as directed. 5. If not effective after 2 dose notify primary care provider.”

On 1/27/2022, I interviewed administrator Jennifer Slater at the facility. Ms. Slater's statements were consistent with Ms. Rowe and the incident report. Ms. Slater reported Staff Person A received resident rights training upon hire at the facility.

On 1/27/2022, I attempted to interview Resident C at the facility. I was unable to engage Resident C in meaningful conversation. I observed Resident C's wrists and forearms, I did not observe any marks or bruises.

On 1/31/2022, I interviewed Ms. Cooper by telephone. Ms. Cooper's statements were consistent with Ms. Rowe, Ms. Slater, and the incident report. Ms. Cooper reported she heard Staff Person A tell Resident C she "did not belong at the facility, she belonged in a psyche ward." Ms. Cooper said she confronted Staff Person A and told her she cannot speak to a resident in that manner.

Ms. Cooper reported she received resident rights training when she started at the facility. Ms. Cooper stated she did not know whether Staff Person A received resident rights training at the facility.

On 2/1/2022, I received Staff Person A's residents rights training documents via email. The documents read Staff Person A received a copy of resident rights on 6/14/21.

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) The policy describing the rights and responsibilities of patients or residents required under subsection (1) shall include, as a minimum, all of the following:** **(l) A patient or resident is entitled to be free from mental and physical abuse and from physical and chemical restraints, except those restraints authorized in writing by the attending physician or a physician's assistant to whom the physician has delegated the performance of medical care services for a specified and limited time or as are necessitated by an emergency to protect the patient or resident from injury to self or others, in which case the restraint may only be applied by a qualified professional who shall set forth in writing the circumstances requiring the use of restraints and who shall promptly report the action to the attending physician or physician's assistant. In case of a chemical restraint, a physician shall be consulted within 24 hours after the commencement of the chemical restraint.**
ANALYSIS:	The interviews with Ms. Rowe, Ms. Slater, Ms. Cooper, along with review of the incident report, revealed former Staff Person A got into a verbal and physical incident with Resident C. Staff Person A was terminated after the incident for violating Resident C's right to be free from mental and physical harm. Although Staff Person A received resident rights training, Staff Person A acted in a manner that caused harm to Resident C.
CONCLUSION:	**VIOLATION ESTABLISHED**

I shared the findings of this report with licensee authorized representative Lou Andriotti by telephone on 03/09/2022. Mr. Andriotti reported Staff Person A was terminated immediately after the incident and staff were re-trained regarding resident rights.

IV. RECOMMENDATION

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

02/02/2022

Lauren Wohlfert Date
Licensing Staff

Approved By:

03/07/2022

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