GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 25, 2022

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

RE: License #:	AH410397992
Investigation #:	2022A1021032
	Vista Springs Wyoming

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 #:	AH410397992
Investigation #:	2022A1021032
Complaint Receipt Date:	02/28/2022
Investigation Initiation Date:	03/01/2022
Report Due Date:	04/30/2022
Licensee Name:	Vista Springs Wyoming LLC
Licensee Address:	Ste 110 2610 Horizon Dr. SE Grand Rapids, MI 49546
Licensee Telephone #:	(616) 259-8659
Administrator:	Mackenzie Ferguson
Authorized Representative:	Louis Andriotti, Jr.,
Name of Facility:	Vista Springs Wyoming
Facility Address:	2708 Meyer Ave SW Wyoming, MI 49519
Facility Telephone #:	(616) 288-0400
Original Issuance Date:	12/10/2019
License Status:	REGULAR
Effective Date:	06/10/2021
Expiration Date:	06/09/2022
Capacity:	147
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A does not receive medical attention.	No
Resident A had physical altercation with Resident B.	No
There is no hot water at the facility.	Yes
Additional Findings	No

III. METHODOLOGY

02/28/2022	Special Investigation Intake 2022A1021032
03/01/2022	Special Investigation Initiated - Telephone interviewed complainant
03/02/2022	Inspection Completed On-site
03/25/2022	Exit Conference

ALLEGATION:

Resident A does not receive medical attention.

INVESTIGATION:

On 2/28/22, the licensing department received a complaint from Adult Protective Services (APS) with allegations Resident A does not receive required medical attention. APS denied this complaint.

On 3/1/22, I interviewed Spectrum Health Butterworth social worker Kaylee Nellett by telephone. Ms. Nellett reported Resident A reported to her that medical staff do not see her at the facility. Ms. Nellett reported Resident A has an infection on her finger that is not being treated properly.

On 3/2/22, I interviewed Resident A at the facility. Resident A denied allegation that she has an infection on her finger. Resident A reported when she moved into the facility, she agreed to be seen by a physician that comes to the facility. Resident A reported she has only seen the physician once and she does not feel this is adequate. Resident A reported she was recently in the hospital and has not been

seen by the physician. Resident A reported she has not voiced these concerns to management at the facility.

On 3/2/22, I interviewed administrator Mackenzie Ferguson at the facility. Ms. Ferguson reported the facility has a physician that comes weekly to the facility. Ms. Ferguson reported at minimum residents are seen once every three months. Ms. Ferguson reported if a resident has a change in status, they will be seen by the physician. Ms. Ferguson reported a resident, family member, or staff member can request for a resident to see the physician, if needed. Ms. Ferguson reported she works closely with the physician to ensure residents receive the care they require. Ms. Ferguson reported Resident A moved into the facility in July 2021. Ms. Ferguson reported Resident A has requested not to see the physician if there were no changes to medical concerns or medications due to costs. Ms. Ferguson reported Resident A has been seen by the physician in July and October. Ms. Ferguson reported Resident A will see the physician later this week to follow up regarding the emergency room visit on 2/26/22. Ms. Ferguson reported Resident A has not had a major medical issues or concerns that have required Resident A to see the physician.

I reviewed Home MD House Call Services documentation. The documentation revealed Resident A was seen by the service 7/22/21, 10/20/21, and 1/25/22.

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents; adoption; posting and distribution; contents; additional requirements; discharging, harassing, retaliating, or discriminating against patient exercising protected right; exercise of rights by patient's representative; informing patient or resident of policy; designation of person to exercise rights and responsibilities; additional patients' rights; definitions.**
	(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: **(o) A patient or resident is entiled to adequate and appropriate pain and symptom management as a basic and essential element of his or medical treatment.**
ANALYSIS:	Interviews with management and review of documentation revealed lack of evidence to support the allegation that Resident A does not receive medical attention.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A had physical altercation with Resident B.

INVESTIGATION:

The complainant alleged Resident A had a physical altercation with Resident B. The complainant alleged Resident A was grabbed by Resident B. The complainant alleged Resident A's wrist is swollen and was injured during this altercation. The complainant alleged Resident A was given medication to make her sleep and no staff members followed up with her.

Resident A reported she was walking down the hallway and told Resident B that his nose was running. Resident A reported Resident B then grabbed her wrist and would not let go. Resident A reported a maintenance worker saw the incident. Resident A reported no staff members followed up with her. Resident A denied that she was provided medication to make her sleep. Resident A could not provide a date or time when this event occurred.

Ms. Ferguson reported the incident between Resident A and Resident B occurred on 12/28/21. Ms. Ferguson reported Resident A can be rude to other residents and yell at them. Ms. Ferguson reported Resident B tends to wander throughout the facility. Ms. Ferguson reported Resident B has increased secretions from his nose. Ms. Ferguson reported Resident B has no prior history of behaviors with other residents. Ms. Ferguson reported it is unclear exactly what happened between the two residents because no staff members were present. Ms. Ferguson reported she believes Resident A yelled at Resident B and this made Resident B upset. Ms. Ferguson reported following the incident, Resident A complained of no pain or injuries. Ms. Ferguson reported no injuries were observed on Resident A. Ms. Ferguson reported she followed up with Resident A the following day and Resident A complained of no pain or injuries. Ms. Ferguson reported earlier this week Resident A complained of wrist pain due to this incident. Ms. Ferguson reported an x-ray was taken and there are no injuries to Resident A. Ms. Ferguson reported Resident A does have a bump on her wrist due to arthritis. Ms. Ferguson reported following the incident, Resident B's service plan was updated to reflect care staff to keep the two residents separated. Ms. Ferguson reported there have not been any more incidents between Resident A and Resident B. Ms. Ferguson reported Resident A was issued a 30 day notice earlier this week due to non-payment.

On 3/2/22, I interviewed maintenance worker Shawn Rawlings at the facility. Mr. Rawlings reported he heard Resident A yelling help and ouch. Mr. Rawlings reported he observed Resident B to be holding Resident A's arm. Mr. Rawlings reported he intervened and Resident B walked away from Resident A. Mr. Rawlings reported Resident A reported no injuries or pain after the incident. Mr. Rawlings reported Resident A was very upset that Resident B was able to wander around the facility. Mr. Rawlings reported he is unsure what started the incident as he was not present,

and no other caregivers were present. Mr. Rawlings reported following the incident a caregiver evaluated Resident A for injuries and pain. Mr. Rawlings reported Resident B has no history of behaviors with other residents. Mr. Rawlings reported Resident A tends to be verbally mean to other residents. Mr. Rawlings reported he does not recall seeing any marks or bruises on Resident A following the incident.

I reviewed radiology report for Resident A that was dated 2/23/22. The report read,

> *"The radiocarpal joint is anatomically aligned. However, there is joint space narrowing and sclerosis. The first and second carpometacarpal joints are narrowed and sclerotic due to mild degenerative changes. No fracture or dislocation is seen. There is soft tissue swelling. Mild degenerative joint disease or the left wrist, but no fracture seen."*

I reviewed the medication administration record (MAR) for Resident A for 12/28/21-12/31/21. The MAR revealed Resident A was not provided any as needed medications for pain or sleep.

I reviewed incident report for the incident between Resident A and Resident B. The narrative read,

> *"staff reported to HWO that during medication pass, community member stated that she was having discomfort in her wrist. Staff member stated that was a discolored area, when asked what happened community member stated that during dinner another community member grabbed her wrist. Community member was able to move her wrist and did not want to be sent to the hospital. All responsible parities notified."*

The corrective measures read,

> *"redirect members that are near community member, assess member for any increased pain, report pain to PCP."*

I reviewed observation notes for Resident A. The notes read,

> *"12/28: during medication pass community member expressed discomfort in her left wrist staff observed discolored area, community member stated another resident put his hands on her during dinner, all responsible parties notified.*
> *12/29: assessed member due to recent incident member had no complaints of pain at this time.*
> *2/22: Spoke to member in regards to 30 day discharge notice, member stated she understood. Member did state that she was sore, HWO asked what was sore, she stated her wrist was, HWO asked what happened, she stated that community member grabbed her wrist a while ago. There were no reports in regards to this. HWO contacted PCP and requested order for an x-ray of left wrist. No bruising present at this time, HWO assessed slight swelling.*

2/23: HWO assessed member when x-ray tech was present. Member had discoloration to left wrist and stated it was still sore. X-ray was completed, awaiting results."

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.**
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:	Interviews with employees and review of documentation, revealed there was an altercation between Resident A and Resident B. Following the incident, the facility followed up with Resident A, provided medical attention, and implemented measures to prevent future occurrences from happening.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

There is no hot water at the facility.

INVESTIGATION:

The complainant alleged Resident A reported there is no hot water at the facility.

Resident A reported she showers very early in the morning because there is no hot water in the shower in the afternoon. Resident A reported there is hot water in her kitchen and in the sink but not in the shower. Resident A reported no concerns with water temperatures elsewhere.

I took the temperature in Resident A's shower. The temperature of the water was 92 degrees Fahrenheit.

APPLICABLE RULE	
R 325.1970	**Water supply systems.**
	(7) The temperature of hot water at plumbing fixtures used by residents shall be regulated to provide tempered water at a range of 105 to 120 degrees Fahrenheit.
ANALYSIS:	Water temperature taken at the facility revealed the water temperature was not hot.
CONCLUSION:	**VIOLATION ESTABLISHED**

I attempted to exit conference with authorized representative Louis Andriotti, Jr. by telephone. The report was sent electronically to Mr. Andriotti on 3/25/22.

IV. RECOMMENDATION

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

Kimberly Horst 3/4/22

Kimberly Horst Date
Licensing Staff

Approved By:

Andrea L. Moore 03/11/2022

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