GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 19, 2022

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

RE: License #: AL410400138

Investigation #:
2022A0357011

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 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) 356-0100.

Sincerely,

Arlene B. Smith

Arlene Smith, MSW, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 916-4213

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL410400138
Investigation #:	2022A0357011
Complaint Receipt Date:	03/17/2022
Investigation Initiation Date:	03/17/2022
Report Due Date:	05/16/2022
Licensee Name:	Vista Springs Northview, LLC
Licensee Address:	Ste 110 2610 Horizon Dr. SE Grand Rapids, MI 49546
Licensee Telephone #:	(616) 364-4690
Administrator:	Jenny Bishop
Licensee Designee:	Louis Andriotti, Jr.
Name of Facility:	Vista Springs Terrace Cove
Facility Address:	3740 Vista Springs Ave NE Grand Rapids, MI 49525
Facility Telephone #:	(616) 364-4690
Original Issuance Date:	04/08/2020
License Status:	REGULAR
Effective Date:	10/08/2020
Expiration Date:	10/07/2022
Capacity:	20
Program Type:	AGED, ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A's INR readings were not reported to the Spectrum Health Coumadin Clinic as required.	Yes
The licensee did not obtain lab work for Resident A that had been ordered by his physician.	Yes
The licensee did not obtain lab work for Resident A that had been ordered by his physician**.**	Yes
Resident A's care at the facility is "questionable" as indicated by multiple pressure wounds and poor wound care.	No
Resident A's medication are not administered as prescribed.	Yes
Additional Findings	Yes

III. METHODOLOGY

03/17/2022	Special Investigation Intake 2022A0357011
03/17/2022	Special Investigation Initiated - Telephone to the facility
04/04/2022	Contact - Telephone call made To Resident A's physician office, left message to call me back.
04/04/2022	Contact - Telephone call made Telephone interview with Family Member 1.
04/05/2022	Inspection Completed On-site Received three Incident/Accident Reports and reviewed the changes in Resident A' s Coumadin.
04/05/2022	Contact - Face to Face Interview with Stacy Rowe, Wellness Director for the Lodge, and the Administrator, Jenny Bishop.
04/05/2022	Contact - Face to Face Interview with Resident A and Family Member 1.
04/06/2022	Contact – Telephone call made To Registered Nurse Case Manager at Resident A's physician's office
04/07/2022	Contact - Document Received Received documents related to the care of Resident A from his physician's office.

04/08/2022	Contact - Telephone call received From Diane Schaffer MHA concerning medical records on Resident A.
04/12/2022	Contact - Document Received Received E-mail from Rachel Green, Nurse Case Manager with Resident A's physician.
04/14/2022	Contact - Document Received Email from Diane Schaffer, MHA, Resident A's Medical Records.
04/14/2022	Contact - Document Sent Sent our letter explaining our request for Medical Records.
04/18/2022	Contact - Document Received Received and reviewed medical records on Resident A from the Spectrum Health Coumadin Clinic.
04/22/2022	Contact – Telephone interviews with Stacey Rowe, Joe Jansen, and Jenny Bishop.
05/02/2022	Referral to Centralized Intake, Adult Protective Services.
05/04/2022	Inspection completed on site. Reviewed Resident A's MAR's and other documentation.
05/19/2022	Exit conference conducted by telephone with the Licensee Designee, Louis Andriotti Jr.

ALLEGATION: Resident A's INR readings were not reported to the Spectrum Health Coumadin Clinic as required.

The complaint originated in BCHS and was sent to BCAL OnLine Complaints and read as follows: *'Multiple Staff turnover since Summer with No wellness RN and transition to non RN wellness director. I was notified by Spectrum Health Coumadin Clinic in December 2021 of an ongoing issue since July/August with multiple delays in patient INR management caused by Vista Springs poor compliance with obtaining patient blood work and medication adjustments. This is all documented-on Spectrum Health EMR System. This has led to multiple patient hospital admissions due to bleed/anemia etc. The facility continues with medication mistakes even with extra communication and fax of orders by myself. The patient's care at the facility is questionable as patient has suffered multiple pressure wounds and poor wound care. Patient is actively following with Spectrum Wound Clinic with poor healing noted and aggressive wound/interventions discussed. Another current situation with patient recent discharge from hospital with low hemoglobin at 7.3 and our office with*

repeated requests for lab work to repeat Hemoglobin level with orders sent and verbal discussions on 2/24/22. I have had multiple conversations with facility and visiting nursing with still no labs obtained at current date of 3/17/22. I have discussed with patient family and facility for poor patient care with recommendations for patient transfer to higher level of care at a different facility with no changes made.'

This investigation report will not address the claim of multiple staff turnover as this issue is not rule related.

INVESTIGATION: On 04/04/2022, I spoke with Resident A's RN Case Manager (RN CM) from Resident A's physician's office. The RN CM stated that their office had been notified from the Spectrum Health Coumadin Clinic that they have not received Resident A's INR's reports from the staff at Vista Springs where Resident A is living, back to July and August of 2021. The RN CM stated that the same concern was for September, October, November, December 2022, and to the present date. RN CM stated that when they called and spoke to staff, there were numerous excuses given including the facility's dependence on outside resources to do Resident A's blood draws and his INR's. There were no clear explanations as to who would draw Resident A's blood as prescribed by the Spectrum Health Coumadin Clinic and Resident A's physician at the Vista Springs facility.

RN CM stated that the Spectrum Health Coumadin Clinic staff reported that they had to call the facility multiple times and leave messages with no follow-up. RN CM stated Resident A had recently been in the hospital and was discharged with a low hemoglobin at 7.3 and Resident A's physician's office called with repeated requests for lab work to repeat Resident A's Hemoglobin level with orders sent and verbal discussions on 2/24/22. RN CM stated that they have had multiple conversations with facility staff and visiting nursing however still no labs were obtained as of 3/17/22. RN CM stated she faxed the orders for the blood draw several times followed by telephone calls with no response from staff at the facility. RN CM stated she spoke with a staff named "Joe" and explained to him the importance of knowing Resident A's Coumadin levels. RN CM reported that she asked Joe who does the blood draws for the facility, and it was not clear who was responsible to do the blood draws. RN CM reported that before Joe there was "Becky" and when they made the calls to request Resident A's INR's there would be weeks without any calls being returned and there were no blood lab works completed or his INR numbers. RN CM reported that Resident A was declining, and he had bleeding issues and high potassium levels. RN CM reported that she had sent multiple requests for a repeat on Resident A's hemoglobin and left many messages. They would re-fax the same orders for the blood draw and they would not receive any response from the facility. RN CM stated she would send me Medical Records on Resident A that would demonstrate the issues they have had and are still having.

On 04/04/2022, I called Resident A's, Family Member 1 (FM1). He explained that there have been discussions of Resident A going to a skilled facility. He stated that Resident A does not want to move to a different facility because he has been in this

facility for three years and his friends are close by and visit him often. He also stated that Resident A's church is close by, and they come and pick him up for church on Sundays.

On 04/05/2022, I made an unannounced inspection of the facility. I interviewed the Administrator, Jenny Bishop and Wellness Director, Stacy Rowe. Resident A was admitted on 03/20/2019, to the facility. Ms. Rowe stated that she worked in the facility and left her job for a year and then came back in December 2021. She reported that she is now the Wellness Director in the Lodge. She explained that they now use a phone report where they call in the INR numbers and they do not talk to a person when they report. She stated that if there is a change in his medication the Coumadin Clinic will send a fax over. She reported that they had to have a physician's order to change Resident A's usage of Warfarin and she made sure that happened when she worked there before and since she has returned. She reported that recently (02/23/2022) Resident A's medications had been changed to Eliquis. Ms. Bishop said she could pull up the changes that had been made in Resident A's, Warfarin. Ms. Rowe stated that when she was here before she always documented when they sent the results of the INR's and what the changes were. She reported that "Becky" was here, and she did not recall seeing anything written down about the changes in Resident A's medications by Becky or any staff. She reported that Becky no longer works at the facility. Both Ms. Bishop and Ms. Rowe stated that Joe Jansen is the new Wellness Director at the Vista Springs Terrace Manor and Vista Springs Terrace Cove. Ms. Rowe stated that they did not receive a request for Resident A's hemoglobin levels. Both reported that Resident A has four different providers, including The Care Team, Tandem 356, a Home Health agency and a nurse from the Wound Clinic. They both reported that it can be confusing regarding who is doing what with Resident A's care.

Ms. Bishop is fairly new at the facility and Ms. Rowe returned after being off for a year. I asked how they could demonstrate that they had taken Resident A's INR's and that they had been sent to the Spectrum Health Coumadin Clinic. Ms. Bishop provided me with sheets of Resident A's current Medications. She highlighted the medications Warfarin, the Warfarin (Coumadin) and Warfarin Sodium, 70 times on four pages. Each of these had various start and end dates. She stated that each highlighted medication was a result of their staff submitting Resident A's INR's which resulted in a change of Resident A's prescribed Warfarin. On page 3 of this documentation was the following: "Anti-coagulant PTINR 1 X Week on Thursdays, Directions: PTINR blood draw – Lab will be coming on Tuesdays, early morning, Med Pass Notes: Once receive lab report – fax results to cardiology office Fax (number listed) Scheduled Dates 04/27/2021-No End Date."

On 04/05/2022 I met Resident A and FM 1. They explained that Resident A is having surgery on 04/14/2022, to remove his left leg. FM 1 showed me Resident A's motorized wheelchair. He explained that somehow when Resident A was driving the wheelchair, he had hit the button to go faster and ran into a door frame and split his shin open, and the wound was severe. Resident A went to the hospital for care and

now has a home health nurse coming to change his dressings three times a week. FM1 stated that the dressing changes are required four additional times per week and since the facility cannot do his dressing changes, Resident A's four sons come and do the dressing changes on the other four days. It was learned that Resident A had gangrene in his large left toe.

On 04/07/2022, I received faxed documents from the RN Case Manager, containing medical information on Resident A. I reviewed these documents on 04/16/2022, and again on 04/26/2022. There were many pages from Resident A's physician's office and there are numerous references to Resident A not having his INR numbers read and sent into the Coumadin Clinic, which would have come from the Vista Springs facility. Some were not reported for three weeks or more. I reviewed a note dated 12/01/2021 regarding a conversation between "Becky" staff at Vista Springs and the RN CM. The note stated that Becky told RN CM that they do not have a Wellness RN anymore and that that Becky is now the Wellness Director. RN CM spoke with Becky from the facility, and she reported to her that the Coumadin Clinic had not received the INR results on Resident A for a couple of weeks and informed her that this problem has been going on for a couple of months. According to Becky she stated she had faxed them over, but RN CM said they had not been received. The RN CM was asking Becky to work out a contract with the Coumadin Clinic on how to communicate the INR numbers. RN CM asked Becky about Resident A's self-monitoring device and Becky reported that she has not been able to find his machine and she thought staff had taken the INR machine. Becky stated that she tried to get another one but the company, would not provide a new one until the other one was found. Becky reported that Spectrum Health had drawn Resident A's labs weekly, and the RN CM explained that the clinic would have been able to see his results if they had completed his blood draws.

There were notes provided that the Spectrum Health Coumadin Clinic had called Resident A's physician's office to report that they had not received the required INR readings. The physician's office wrote that Resident A needed to be in a facility that offered a higher level of care. The notes indicated that Resident A had fallen out of bed and was diagnosed with a fractured pelvis, along with anemia due to blood loss and blood coagulation disorder. He was admitted to the Spectrum Hospital on 12/22/21 and was discharged on 12/27/2022 with "a diagnosis of fractured pelvis, anemia due to blood loss and blood coagulation disorder." It was learned later that Resident A had fallen out of his bed which resulted in his fractured pelvis.

On 04/18/2022, I received the requested documents related to Resident A's readings of his INR numbers and medical information from the Spectrum Health Coumadin Clinic. There were 198 pages to review and there were numerous entries that indicated the Vista Springs staff had not called in Resident A's readings. The clinic notes indicated that the former staff Becky, reported the machine was stolen and the company would not replace it and therefore they could not send in Resident A's readings. Other entries stated that they ran out of the paper slips used by the machine. There were numerous reports that the staff of the Coumadin Clinic

telephoned the facility and no one answered and other times they left messages to be called back and no calls were returned. Some voice mails were full, and they could not leave a message. If the INR numbers were phoned in, they would respond to the pharmacy to change the amount of his Coumadin. If they did not have the INR numbers, they could not change or verify the dosage instructions for the medications of Coumadin. I reviewed a note dated 11/30/2021 from the Coumadin Clinic that read: *'Patient is 3 weeks overdue to have his…PT/NIR drawn. We have been unsuccessful at reaching this patient via phone.'* Documentation dated 12/13/21; *'Called Vista Springs and left message, requesting a call back and also requesting INR be drawn today. Also left clinic phone number on Voicemail message along with hours phones are in service.'* On 12/14/21 the Clinic requested an INR again. Documentation read: *'Becky states she is out of strips for his INR on Monday.'* These are a few examples that I reviewed related to the staff at the facility not providing the requested INR numbers.

Everyone who I interviewed during this investigation said they could meet all of Resident A's needs in this facility and there was no discharge noticed given to Resident A or his family members. It was learned during this investigation that one of Resident A's physicians had put Resident A on Eliquis and the IRN's were no longer needed. Resident A recently had emergency surgery to remove his leg below the knee and then with another surgery they had to remove above his knee and he was in the hospital for an extended period of time. He just recently returned to the facility.

On 05/19/2022, I conducted a telephone exit conference with Louis Andriotti Jr., Licensee Designee, and he agreed with my findings.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being {333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.
ANALYSIS:	According to my review of the documentation from Resident A's physician and from the Spectrum Health Coumadin Clinic, the staff of the facility were not reporting all of the required INR numbers to the clinic consistently and therefore they could not adjust his Coumadin levels.

	The Coumadin Clinic made Resident A's physician's office aware that they had not received Resident A's INR's for several weeks. The Registered Nurse Case Manger contacted the staff of the facility who reported that Resident A's INR machine was missing. Therefore, they had no equipment to complete his ordered INR numbers. They also reported they were out of the strips to use in the INR machine. The order for Resident A was to have his INR numbers reported to the Spectrum Health Coumadin Clinic first on a weekly basis but then more INR's results were required due to Resident A's change of condition. The facility staff were unable to consistently provide the special medical procedures by using the INR machine and report these numbers to Resident A's physician and to the Spectrum Health Coumadin Clinic. Therefore, a violation is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	The facility staff reported to the Registered Nurse Case Manager on 12/01/2022 that the facility did not have Resident A's INR machine. The staff of the facility were required to obtain Resident A's INR numbers and report them to the Spectrum Health Coumadin clinic. If they did not have the machine they could not take and report Resident A's INR numbers and they were out of the strips to use with the INR. His INR numbers were three weeks overdue. The facility failed to protect Resident A by not providing his INR numbers to the Coumadin Clinic. They failed to protect and provide for Resident A's safety.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: The licensee did not obtain lab work for Resident A that had been ordered by his physician.

INVESTIGATION: On 04/06/2022 The RN Case Manager (RN CM) stated that she has had multiple conversations with facility and visiting nursing with still no labs obtained at current date 03/17/2022. RN CM stated Resident A had recently been in the hospital and he left there with a with low hemoglobin at 7.3 and Resident A's physician's office called with repeated requests for lab work to repeat Resident A's Hemoglobin level with orders sent and verbal discussions on 2/24/22. RN CM stated that they have had multiple conversations with facility staff and visiting nursing with still no labs obtained as of 3/17/22. RN CM stated she faxed the orders for the blood draw several times followed by telephone calls with no response from facility staff. RN CM stated she spoke with a staff named Joe (no last mane provided) and explained to him why they needed Resident A's blood work completed along with needing his INR's. RN CM stated that she had explained to Joe the importance of knowing Resident A's Coumadin levels. RN CM reported that she asked Joe who does the blood draws for the facility, and it was not clear who was responsible to do the blood draws. RN CM reported that before Joe there was Becky (no last name provided) and when they made the calls to request the Resident A's INR's there would be weeks without any calls being returned and there were no blood lab works completed. RN CM reported that Resident A was declining from poor care, and he had bleeding issues and had high potassium levels. RN CM reported that she had sent multiple requests for a repeat on Resident A's hemoglobin and left many messages. They would re-fax the same orders for the blood draw and they would not receive any response from the facility. RN CM stated she would send Medical Records on Resident A that would demonstrate the issues they have had and current issues that they still are having.

On 04/05/2022, Ms. Rowe stated that they did not receive a request for Resident A's hemoglobin levels.

On 04/07/2022, I received medical information from Resident A's physician's office from RN, Case Manager. She sent the following: A.F. Associates Family Medicine P.C., for (Resident A) faxed to Vista Springs Northview, dated 01/17/2022, Diagnosis of Anemia and hyperkalemia, signed by Gayle Keider P.A.-C. Test ordered: CBC, BMP.

Fax Transmittal Memo to Vista Springs Northview, dated 02/24/2022, fax number of 616-364-4615, from RN CM, for (Resident A) 2 pages sent, Lab orders attached. Also faxed to The Care Team, Diagnosis of Anemia, CBC, and BMP.
Cover sheet A+ Family Medicine, dated 03/17/2022, to Interim HHC, Fax # 616-719-2928, From RN-CM, Comment, I have sent these lab orders on 2/24/2022 and called Vista Springs multiple times with still no labs. The following was written: "Please bring the attached to attention to RN for this blood draw."

On 04/07/2022, and on 04/26/2022 I reviewed the information, over 100 pages from Resident A's physician's office and there are numerous references to Resident A not having his INR numbers read and sent into the Coumadin Clinic, which would have come from the Vista Springs facility. Some were not reported for three weeks or more and some shorter and some longer. There were notes that the Spectrum Health Coumadin Clinic had called Resident A's physician's office to report that they had not received the required readings.

On 04/22/2022, I spoke by telephone with Joe Janson, Wellness Director and he reported that he did not remember speaking to the RN CM about the order for a blood draw for Resident A.

On 04/22/2022, I spoke by telephone with Stacy Rowe, Wellness Director for the The Lodge. She reported she did help out in Vista Springs Terrace Cove and Vista Springs Terrace Harbor when she came back to work. Ms. Rowe stated that they have had problems with receiving faxes when their fax machine did not work correctly. I confirmed the fax number at the facility, and it was correct. She said it could be possible that they did not receive the faxes that were sent by RN CM. She also stated that they have experienced problems with the agency 'Interim' and they have chosen to discontinue working with this agency, but Resident A's family wanted them to continue with Resident A. Ms. Rowe stated they had secured another agency "The Care Team," to work with Resident A but Interim refused to sign off.

On 04/22/2022, I spoke by telephone with Jenny Bishop, the Administrator. She reported that Becky Bolder, Former Wellness Director, no longer works for the facility and that Joe Janson is their new Wellness Director and he has only been there about three months. She stated that they found one of the requests 02/24/2022, for Resident A's blood draws for a CBC that stated it had also been sent to "The Care Team," and Ms. Bishop stated that the home health agency should have been the agency drawing the blood. She stated that they are not required to have any licensed nurses on staff at the facility. This information indicates that the facility had received the order for the blood draw, but they have no way to draw blood for an ordered CBC. The Administrator said since the order was sent to "The Care Team" (a home health agency) it was their responsibility to draw his blood and have it tested. Later it was learned that the Care team billed for the service, but Interim HHC has already billed for it and Medicare declined the bill.

On 05/19/2022 I conducted a telephone exit conference with Louis Andriotti Jr., Licensee Designee and he agreed with my findings.

APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's

	physician or other health care professional with regard to such items as any of the following: **(d) Other resident health care needs that can be provided in the home. The refusal to follow the instructions and recommendations shall be recorded in the resident's record.**
ANALYSIS:	It was alleged that an order was sent to the facility three times for a blood draw for Resident A. The RN Case Manager provided the documents that had orders for a blood draw for CBC and BMP for Resident A's that were faxed to the facility on 01/17/2022, 2/24/2022, and 03/17/2022. The RN CM testimony said she also called the facility and spoke several staff and still there was no blood draw. Ms. Bishop acknowledged that they did have the faxed paper with the ordered blood draw dated 02/24/2022. She reported it was up to the Home Health, The Care Team, to provide the service since their name was included on the order. None of the staff in the facility who were interviewed would take responsibility to help find an agency to provide the requested blood draw for Resident A's physician prescribed order. This was a health care need that could be provided in the home by finding a home health agency to draw Resident A's blood. The order was sent three times and followed by telephone calls, and this was now two months later and there still was not a blood draw for Resident A. This order contained instructions from Resident A's physician to have his blood drawn and tested. This was a health care need for Resident A and the home staff could have facilitated a home health agency to draw his blood Therefore, this is a violation of the rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A's care at the facility is "questionable" as indicated by multiple pressure wounds and poor wound care.

INVESTIGATION: On 04/05/2022, I made an unannounced inspection of the facility. I interviewed the Administrator, Jenny Bishop and Wellness Director, Stacy Rowe. They acknowledged that Resident A has had difficulty with his health over the course of his stay at this facility. Ms. Bishop has only been at this facility since mid-January 2022 and Ms. Rowe had worked for the facility for about a year and then came back to work for the facility. They stated that Resident A had fallen out of his bed and fractured his pelvis. They explained that Resident A had a severe injury to

his leg when he ran his motorized wheelchair into a doorway and split his shin opened on his left leg. He was sent to the hospital and returned with Interim Home Health Agency doing the dressing changes to his leg injury. They also reported that Resident A's family was very involved in his care and that he has had a specialized mattress to prevent skin breakdowns.

On 04/05/2022, I met with Resident A and FM 1. As in entered Resident A's bedroom FM1 stated that it was good timing when I had arrived because he has just finished his dressing changes and the "smell was awful." FM 1 explained that Resident A required dressings changes to his leg seven days per week and the Home Health Agency only could do three changes per week and therefore he and his three brothers came into the facility and did the other four weekly dressing changes. I asked FM1 if he had any concerns about Resident A's care, and he said he had none. I asked Resident A if he had any concerns about his care at this facility and he said he had none. They both stated they were pleased with his care.

On 04/22/2022, I spoke by telephone with Stacy Rowe, Wellness Director for The Lodge. She stated that when she came back to work for the facility, she had worked in Vista Springs Terrace Cove, and she had worked with Resident A. She confirmed that he did have a special mattress to prevent skin breakdown. She explained that Resident A's skin "was like tissue paper and it could tear very easily." She also reported that Resident A was very weak, and he had significant amounts of pain. She reported that he required the use of a Hoyer lift to be able to lift him out of his bed and into his motorized wheelchair.

On 05/02/2022, I conducted a telephone interview with Ms. Bishop, and she explained that Resident A does not want to get out of his bed for his bath or for changes of his adult protection. Therefore, the staff have to roll him side to side to provide him with a bed bath and to change his adult protection and this can cause stress on his very frail skin. Ms. Bishop stated that they do not provide Resident A with dressing changes and that the Home Health Agency and the family members do his dressing changes. Therefore, she cannot respond to the allegation of 'poor wound care.' She also reported that Resident A has been in the hospital many times and has gone to a rehab facility. Therefore, others have provided his direct care. Ms. Bishop stated that various agencies from Mary Free Bed to the Wound Clinic along with three home health agencies have worked with Resident A and have provided wound care. She stated that the AFC home was not responsible for Resident A's wound care.

On 05/03/2022, I conducted an interview with a direct care staff, Carina Hernandez. She explained she has worked in all of the four Vista Springs on this campus for three years, but most recently she has been in Terrace Cove for the past three months and has worked with Resident A. She reported that Resident A was on Warfarin for an extended period of time, and this has caused him to have very thin skin and he can very easily have a skin tear. She stated in the past he had a sore on his heel but there has been consistent wound care from Tandem 365 and now the

wound is healed. She stated that he has a sore spot on his right butt cheek. She does not know how long it has been there. She said he is receiving would care from home health agencies and it is doing better. She reported that they rotate him in his bed, and they use pillows to help him stay on his side and then they have him to turn on his other side. She stated he does not tolerate these positions for a long length of time but sometimes he can tolerate it for one hour and then he becomes upset and does not want to be on his side. When he is in his wheelchair, they put pillows under him and he complains that he does not like them because he feels he will slide out of his wheelchair even though his foot pedals are raised. Ms. Hernandez stated that Resident A has choices, and they cannot go against his wishes. She expressed her opinion that staff have provided Resident A with good care and that they have not caused any injuries to him.

On 05/19/2022 I conducted a telephone exit conference with Louis Andriotti Jr., Licensee Designee and he agreed with my findings.

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APPLICABLE RULE	
R 400.15305	**Resident protection**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times.
ANALYSIS:	It was alleged that Resident A has received poor wound care. Resident A has been provided with a specialized mattress to prevent wounds. Ms. Rowe and Ms. Hernandez both stated that Resident A has very thin shin and it can tear very easily. Ms. Bishop stated the staff of the facility do not provide wound care to Resident A or dressing changes. Home Health agencies provide wound care and dressing changes three times per week and Resident A's four sons provide dressings changes to Resident A four times per week. Ms. Bishop stated that Resident A does not like to get out of bed therefore staff have to roll him side to side to provide a bed bath along with changes to his adult protection. Ms. Carina Hernandez, direct care staff, stated that Resident A had a wound on his heel that now is completely healed and a sore on his right buttock that receives wound care from Tandem 356 and she reported it is healing. She stated that Resident A is put on his right and left sides and propped up with pillows, but he does not like to be on his side, and he will not stay in this position for a long time. Resident A refuses to have pillows

	underneath him in his wheelchair because he feels he will slide out of the wheelchair. Although the facility staff do not provide wound care or dressing changes, a home health care agency does provide wound care and Resident A's four family members do provide dressing changes to Resident A's leg.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Resident A's medications are not administered as prescribed.

INVESTIGATION: On 05/04/2022 I made an unannounced inspection at the facility. I met with Erin Witten, LPN, who just started at the facility just recently and Stacey Rowe, Wellness Director. Ms. Witten was able to pull some of Resident A's MAR's and a list of each administration of his prescribed medications by date and time. We were able to identify a few missed medications. She made copies of these documents for me.

On 05/05-06/2022 I reviewed these documents.

07/01/2021 07:54 AM Symbicort 160-4.5 MCG Inhaler Note: "Can't find."
07/02/2021 04:13 PM Silver Sulfadiazine 1% Cream, Note: "Unable to get to toe as there was a bandage over it."
07/03/2022 05:05 PM Silver Sulfadiazine 1% Cream, Note: "There is a bandage on the toe."
07/05/2021 08:36 AM Tamsulosin 0.4 Mg Note: "na" (not available).
07/05/2021 11:55 AM Cephalexin 500 Mg Note: "Order completed."
07/05/2021 05:21 AM Cephalexin 500 Mg Note: "Med not available."
07/06/2021 10:59 AM Silver Sulfadiazine 1% Cream Note: "Can't find."
07/26/2021 08:22 AM Aspirin 81 MG Note: "med out."
07/28/2021 07:38 AM Aspirin 81 MG Note: "Out of medication."
07/29/2021 08:38 AM Aspirin 81 MG Note "med not in yet."
07/30/2021 09:41 AM Flonase Sensimist 27.5MCG SPR Note: "none."
07/30/2021 09:40 AM Aspirin 81 MG Note : "none."
07/31/2021 11:20 AM Aspirin 81 MG Note: "not in cart yet."
08/01/2021 11:20 AM Aspirin 81 MG Note: "not in yet."
08/06/2021 07:41 AM Aspirin 81 MG Note: "medication not in stock."
08/07/2021 09:02 AM Aspirin 81 MG Note: "med out."
08/11/2021 04:24 PM Warfarin 2.5 Mg (1/2t =1.25mg (Coumadin 2.5 Tab (1/2t = 1.2) Note: "not get this dose today."
08/16/2021 08:02 PM Ted Hose Note: "Not on."
08/17/2021 04:35 PM Warfarin 2,5 Mg (1/2t = 1.25mg (Coumadin 2.5 Tab(1/2t=1.2 Note: "Don't get this dose today."
08/18/2021 04:35 PM Warfarin 2,5 Mg (1/2t = 1.25mg (Coumadin 2.5 Tab(1/2t=1.2

Note: Don't get this does today."
08/19/2021 06:39 AM Omeprazole Dr 20 Mg Note: "med not ordered."
08/21/2021 09:23 AM Torsemide 20 Mg Note: "not in yet."
08/23/2021 08:30 AM Torsemide 20 mg Note: "Refused – Other."
08/23/2021 05:41 PM Warfarin 2,5 Mg (1/2t = 1.25mg (Coumadin 2.5 Tab(1/2t=1.2 Note: "dup." (duplicate)
08/25/2021 08:27 AM Torsemide 20 mg Note: "Refused – Other."
08/26/2021 08:33 AM Torsemide 20 mg Note: "doubled in computer."
08/09/202103:19 PM Warfarin 2,5 Mg (1/2t = 1.25mg (Coumadin 2.5 Tab(1/2t=1.2 Note: "REFUSED -Refused by Resident."
09/08/2021 03:19 PM Warfarin 2,5 Mg (1/2t = 1.25mg (Coumadin 2.5 Tab(1/2t=1.2 "REFUSED -Refused by Resident."
09/13/2021 07:24 AM Aspirin 81 MG tablet chew Note: (Refused- other)
09/14/2021 07:39 AM Aspirin 81 MG tablet chew Note: "med out."
09/16/2021 07:33 AM Aspirin 81 MG tablet chew Note: "med out."
09/21/2021 04:45 PM Warfarin 2,5 Mg (1/2t = 1.25mg (Coumadin 2.5 Tab(1/2t=1.2 Note: "REFUSED -Refused by Resident."
10/03/2021 08:00 PM Ted Hose Note: "(Refused - Other) Not on."

This was a sampling of Resident A's MAR's, which demonstrates that his prescribed medications were not administered. These samplings of notes include: "Meds were out, not in stock, not available, not in the cart, not in yet, out of medication, med not available, can't find, med not ordered, Ted hose not on, and cream to put on his toe but the toe was bandaged so they could not put the Silvadene 1% cream on,". These notations confirm that Resident A did not receive all of his prescribed medications and prescribed treatments. The notes indicated that the medicine was out of stock, medication was not in yet, medication was not available, not in the cart, or medication not ordered.

On 05/19/2022 I conducted a telephone exit conference with Louis Andriotti Jr., Licensee Designee and he agreed with my findings.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being {333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.

ANALYSIS:	It was alleged that Resident A did not receive all of his medications. Upon review of several of Resident A's MAR's and other documentations it was found that his prescribed medications were not administered due to the medications not being available. In addition, Resident A had an order for Ted Hose and staff reported discovering them not on him. He was prescribed Silvadene 1% cream for his toe and the toe was bandaged and the staff documented they could not put the cream on his toe. Resident A's Prescription medication was not administered, and Resident A's special medical procedures were not given or applied as prescribed. Therefore, a violation is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITONAL FINDINGS: On 05/04/2022, I made an unannounced inspection at the facility. I met with Erin Witter, LPN, who just recently started at the facility and Stacey Rowe, Wellness Director. Ms. Witter was able to pull Resident A's MAR's and a list of each administration of his prescribed medications by date and time. We were able to identify a few missed medications and treatments. I asked Ms. Witter if she had seen any documentation that a staff had called Resident A's physician or the appropriate health care professional to report that Resident A had not received his medications. She reported that she had not seen any documentation that would indicate the staff had contacted his doctor or any health care professional and therefore there would not be any recorded instructions.

On 05/05-06/2022, I reviewed some of Resident A's MAR's and some printed sheets with his medications, the date, the time and the staff 's initials and reasons why administration or treatments did not occur. The notes I reviewed indicated that the medicine was out of stock, not in yet, not available, not in the cart, med not ordered, and med was out. When I reviewed these documents, I did not find any written documentation that a health care professional was contacted if there was a medication error, or if Resident A refused a medication or a procedure.

On 05/19/2022 I conducted a telephone exit conference with Louis Andriotti Jr., Licensee Designee and he agreed with my findings.

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions:

	(f) Contact the appropriate health professional if a medication error occurs or when a resident refuses prescribed medication or procedures and follow and record the instructions.
ANALYSIS:	It was alleged that Resident A did not receive some prescribed medication due to various reasons. He refused some medications and procedures. Ms. Witter acknowledged that she did not find any documentation that a health care professional had been contacted when medications were not administered or refused by Resident A. I did not find any documentation that would indicate the staff had contacted a health care professional for refusals, or missed medications, or treatments or procedures. Therefore, there is a violation to the rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

I recommend the Licensee provide an acceptable plan of correction and the license remain unchanged.

Arlene B. Smith 05/19/2022

Arlene B. Smith, MSW Date
Licensing Consultant

Approved By:

Jerry Hendrick 05/19/2022

Jerry Hendrick Date
Area Manager