GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 11, 2022

Louis Andriotti, Jr.
IP Vista Springs Washington Place OpCo, LLC
Ste 110
2610 Horizon Drive SE.
Grand Rapids, MI 49546

RE: License #: AL500393430
Investigation #: 2022A0990023
Vista Springs Washington Place - Spring Harbor

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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.

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 (248) 975-5053.

Sincerely,

LaShonda Reed, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste 9-100
Detroit, MI 48202
(586) 676-2877

enclosure

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

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AL500393430 |
| | |
| **Investigation #:** | 2022A0990023 |
| | |
| **Complaint Receipt Date:** | 06/23/2022 |
| | |
| **Investigation Initiation Date:** | 06/24/2022 |
| | |
| **Report Due Date:** | 08/22/2022 |
| | |
| **Licensee Name:** | IP Vista Springs Washington Place OpCo, LLC |
| | |
| **Licensee Address:** | Ste 110<br>2610 Horizon Drive SE.<br>Grand Rapids, MI 49546 |
| | |
| **Licensee Telephone #:** | (616) 710-2049 |
| | |
| **Administrator:** | Kristine Djelevic |
| | |
| **Licensee Designee:** | Louis Andriotti, Jr. |
| | |
| **Name of Facility:** | Vista Springs Washington Place - Spring Harbor |
| | |
| **Facility Address:** | 11900 Vista Springs Blvd.<br>Washington Township, MI 48095 |
| | |
| **Facility Telephone #:** | (586) 331-9400 |
| | |
| **Original Issuance Date:** | 09/27/2019 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 03/27/2022 |
| | |
| **Expiration Date:** | 03/26/2024 |
| | |
| **Capacity:** | 20 |
| | |
| **Program Type:** | AGED<br>ALZHEIMERS |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Resident A eloped from the facility twice. | Yes |

## III. METHODOLOGY

| | |
|---|---|
| 06/23/2022 | Special Investigation Intake<br>2022A0990023 |
| 06/24/2022 | APS Referral<br>Adult Protective Services (APS) complaint made. |
| 06/24/2022 | Special Investigation Initiated - Telephone<br>I conducted a phone interview with Relative A. |
| 06/30/2022 | Inspection Completed On-site<br>I conducted an unannounced onsite investigation. I interviewed Kristine Djelevic-Administrator/Director/Managing Nurse; Melissa Krzeminski-C-Managing Partner/Administrative Services Manager and Brittany Adam-Scheduler was present. |
| 07/12/2022 | Contact - Document Received<br>I received an email from Emily Poley, APS Investigator. Ms. Poley requested guardians contact information and police reports. I provided guardians' information however, I did not have police reports. |
| 07/13/2022 | Contact - Document Sent<br>I emailed Ms. Djelevic-Administrator requesting police reports. Ms. Djelevic said that she did not have them but provided the police report numbers and indicted that she would request the police reports. |
| 08/08/2022 | Contact - Document Received<br>I reviewed documents regarding Resident A. |
| 08/08/2022 | Contact - Document Sent<br>I emailed Ms. Poley, APS. I requested police reports. Ms. Poley substantiated the APS investigation. |

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| 08/08/2022 | Contact - Telephone call made<br>I called direct care staff named Kim. Kim indicated that she was serving lunch and would call back. No call received back. |
| 08/08/2022 | Contact - Telephone call made<br>I left a detailed message for direct care staff Violet Nikprelaj. |
| 08/08/2022 | Contact - Document Received<br>I reviewed two police reports. |
| 08/08/2022 | Exit Conference<br>I conducted an exit conference with Dr. Louis Andriotti, Jr. licensee designee and Ms. Djelevic administrator. |

**ALLEGATION:**

**Resident A eloped from the facility twice.**

**INVESTIGATION:**

On 06/23/2022, I received the intake via email that was re-assigned. In addition to the above allegations, it was reported Resident A, is a dementia resident at the facility. On 11/27/2021, Resident A eloped from the facility and was about ¼ mile away from the facility. A civilian called the sheriff's department who then contacted Relative A and returned Resident A to the facility. The facility staff was unaware that Resident A had left the facility. Relative A has a police report of the incident. Relative A met with the head of nursing and CEO. A plan was made where staff would check on Resident A every 15 minutes. On 6/5/2022, Relative A had left the facility again and was located at a Taco Bell. Relative A spoke with sheriffs at the facility. Resident A was located by a firefighter who saw Resident A walking. The firefighter called Vista Springs and asked if they had a missing resident and the facility said no. The police department knew that Resident A lived at Vista Springs, so they returned her to the facility. The facility was unaware of her elopement. Relative A spoke with the head of the facility again to ensure that Resident A would be safe there. When Relative A left the facility on 6/5/2022, she saw staff sitting around talking, and not watching the residents. Relative A spoke with Melissa, facility staff about her concerns of Relative A's safety from leaving.

On 06/24/2022, I conducted a phone interview with Relative A. Relative A said that she discharged Resident A from Vista Springs due to the elopement concerns. Resident A first eloped on 11/27/2021 and was found on VanDyke road. Relative A said that the facility did not know that Resident A had eloped. Relative A had a meeting with the director Kristine Djelevic and staff person named Melissa who formed a plan to check Resident A every 15 minutes. In addition to the 15-minute checks there were medication adjustments made with Resident A's Neurologist. Relative A said that a

second elopement occurred on 06/05/2022 in which, she received a call that Relsident A was found at Taco Bell. When Relative A arrived at the facility and spoke to the officer present, he indicated that he had called the facility because Resident A's name was in the system belonging to the home. The officer told her that the facility reported there were no missing residents. They proceeded and brought Resident A back because they knew that she lived there from the prior elopement. Relative A said that Resident A can provide her name and DOB. The officer on the scene was concerned that the facility was not aware that Resident A was missing. Resident A has a private room and had been at the facility since January 2021 and this is her first placement. Relative A said that it has been chaotic and upsetting for Resident A because she discharged her from the home and placed her at Oakleigh of Macomb (Home for the Aged license #AH500394648).

On 06/30/2022, I conducted an unannounced onsite investigation. I interviewed Kristine Djelevic-Administrator/Director/Managing Nurse; Melissa Krzeminski-C-Managing Partner/Administrative Services Manager and Brittany Adam-Scheduler was present. Ms. Djelevic was aware of the allegations and said that a plan was made after Resident A as found at Taco Bell which is located diagonal from the facility. Ms. Djelevic said staff Violet Nikprelaj that answered the phone for the police officer had just completed resident checks therefore, had accounted for all residents and did not have anyone missing. Ms. Djelevic said that Resident A must have gotten outside right after the check was completed. Ms. Djelevic called the Fire Marshal after the incident for advisement on securing the facility more such as adding fog to the windows which prevents the residents from seeing clearly outside of the building. Ms. Djelevic said that typically Resident A mingles and was near the staff most of the time. Once the first incident occur they had considered discharging her, but the family wanted her to remain in the home. Ms. Djelevic said that the typical checks for the residents are hourly however, Resident A's checks were every 15 minutes after the first elopement in November 2021. Ms. Djelevic even recommended that the family hire a private sitter to sit with Resident A.

I interviewed Ms. Krzeminski. Ms. Krzeminski said that she had spoken with the family as well regarding Resident A's elopements. Ms. Krzeminski said that they ordered extra alarms and placed "Do Not Enter" magnets on the doors because Resident A can read and is able to exit after the 15 second delayed egress instructions at the exits which does not sound the alarms that a resident has left. Resident A is ambulatory and walks fast. Ms. Krzeminski said that after the first elopement Resident A was prescribed Risperidone by her physician.

On 08/08/2022, I reviewed documents regarding Resident A. Resident A was admitted to the facility on 01/04/2021. Per Resident A's *Health Care Appraisal,* she is alert but confused. Resident A is diagnosed with anxiety, depression, and insomnia. According to Resident A's *Assessment Plan*, she is fully ambulatory, is able to communicate needs and wants from others, however, has confusion and requires orientation from caregivers. Resident A understands and responds verbally. I reviewed a document called a Functional Evaluation which was updated on 06/01/2022 that documented that

Resident A has had one elopement attempt and one elopement. Resident A attempted to exit the building, but staff heard the door alarms and was able to redirect Resident A back inside of the facility.

On 08/08/2022, I reviewed two police reports. I reviewed police report #2021-00113093 which occurred on 11/27/2021 at 10:12AM. Resident A was located at 65075 VanDyke and was inside of a blue Tahoe with a civilian that called 911. Resident A was unsure where she came from and was disorientated. The caller said that she found Resident A walking alone and appeared confused. The officer called the nearby assisted living facility Vista Springs and spoke with a staff person named Brittany Adams who verified that they had just discovered that Resident A was missing. The report documented that the staff did not hear door alarms when Resident A exited the building. Resident A was returned to the facility.

I reviewed police report #2022-00047087 which occurred on 06/05/2022 at 6:18PM. Resident A was found at Taco Bell (65891 VanDyke) confused. Resident A did not know where she lived. The responding officers ran a LEIN as Resident A provided her name and her name showed up residing at a nearby assisted living facility. The officer called the facility and spoke to a staff person named Violet Nikprelaj. Ms. Nikprela said that they were unaware that Resident A got outside and just noticed that she was unaccounted. The officer transported Resident A back to the facility.

On 08/08/2022, I conducted an exit conference with Dr. Louis Andriotti, Jr. licensee designee and Ms. Djelevic administrator. I informed them of the findings. Dr. Andriotti, proposed that their corrective action plan may include a discharge notice and/or an emergency notice for residents that elope as there can not be changes made to the exits because this would violate fire safety rules. Ms. Djelevic said that after Resident A's first elopement a 30-discharge notice was discussed with the family who opposed this plan. Dr. Andriotti and Ms. Djelevic will meet to discuss the plan of correction once the report is finalized.

| **APPLICABLE RULE** | |
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| **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:** | Based upon the investigation, there is substantial information to support that Resident A was not attended to at all times. The facility is to provide 24-hour supervision and protection to all 20 residents whose diagnoses are aged, dementia, or Alzheimer's.<br><br>Resident A eloped on 11/27/2021 and was found by a civilian that contacted law enforcement. Resident A eloped again on |

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|---|---|
| | 06/05/2022 and was found at a nearby Taco Bell. Both times Resident A was found alone and confused.<br><br>According to the staff Ms. Djelevic and Ms. Krzeminski provisions had been made to secure Resident A such as “Do Not Enter” signs at the doors and the facility is equipped with door alarms. The door alarms do not alert if the person exiting is allowing a 15-second delay before exiting the building. Resident A is still able to read and follow those instructions.<br><br>Although, there were provisions such as 15-minute checks and alarms incorporated, Resident A was able to exit the building and had to be brought back the facility by law enforcement. Resident A was moved to a more secure and larger facility after the second elopement. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

## IV. RECOMMENDATION

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

L. Reed

08/08/2022

LaShonda Reed — Date
Licensing Consultant

Approved By:

Denise Y. Nunn

08/11/2022

Denise Y. Nunn — Date
Area Manager