GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 26, 2023

Louis Andriotti, Jr.
IP Vista Springs Timber Ridge Opco, LLC
Ste 110
2610 Horizon Dr. SE
Grand Rapids, MI 49546

RE: License #: AH190401909
Investigation #: 2023A1027025
Vista Springs Imperial Park at Timber Ridge

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) 241-1970.

Sincerely,

Jessica Rogers

Jessica Rogers, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 285-7433
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH190401909
Investigation #:	2023A1027025
Complaint Receipt Date:	12/27/2022
Investigation Initiation Date:	12/27/2022
Report Due Date:	02/26/2023
Licensee Name:	IP Vista Springs Timber Ridge Opco, LLC
Licensee Address:	Ste 110 2610 Horizon Dr. SE Grand Rapids, MI 49546
Licensee Telephone #:	(303) 929-0896
Administrator/ Authorized Representative:	Louis Andriotti, Jr.
Name of Facility:	Vista Springs Imperial Park at Timber Ridge
Facility Address:	16260 Park Lake Road East Lansing, MI 48823
Facility Telephone #:	(517) 339-2322
Original Issuance Date:	11/04/2020
License Status:	REGULAR
Effective Date:	05/04/2022
Expiration Date:	05/03/2023
Capacity:	40
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident A eloped and passed away.	Yes
Additional Findings	Yes

III. METHODOLOGY

12/27/2022	Special Investigation Intake 2023A1027025
12/27/2022	Special Investigation Initiated - On Site
12/28/2022	Contact - Document Received Police Report#22-00853 received by email. Per police report, APS was contacted by their department.
12/28/2022	Contact - Document Sent Email sent to Ms. Duckworth requesting Resident A's admission contract
12/28/2022	Contact - Document Received Email received with requested documentation
12/28/2022	Contact - Document Sent Email sent requesting Employee #3's file
12/29/2022	Contact – Document Received Email received with Employee #3’s file
12/29/2022	Inspection Completed – BCAL Sub. Compliance
01/04/2023	Contact – Face to Face Observations completed, staff interviewed, and staffing documentation obtained on-site
01/26/2023	Exit Conference Conducted by telephone with Mr. Andriotti, Ms. Brindley, and manager Andrea Moore

ALLEGATION:

Resident A eloped and passed away.

INVESTIGATION:

On 12/24/2022, the Department received an incident report by email which read in part:

> *"At 7:00AM on 12/23/2022, shortly after change of shift when the morning Care Staff [Employee #1] had come on duty and was beginning to assist residents get ready for the day, she heard the snow plow driver yelling for assistance. He indicated there was a woman outside on the ground lying in the snow who was in need of immediate assistance. Two Care Staff members accompanied by the driver immediately ran outside to see resident lying on her back near an entry/exit door in the snow, and realized her fingers were still moving. They carried her inside, where the Care Staff took resident to a nearby nurses office. The resident was dressed appropriately for the outdoors in cold temperatures. One Care Staff member began to remove her wet coat and clothes, while another called 911. Care Staff wrapped her in a blanket and added additional warmed blankets to help raise her body temperature. When EMS arrived they put the resident in a Thermoflect Hypothermia Transport Blanket to radiate body heat and prevent heat loss. Resident was transported to hospital and placed on life support. Resident succumbed to her injuries and died later that day in the Hospital."*

On 12/27/2022, I conducted an on-site inspection at the facility. I interviewed Employee #1 who stated she had cared for Resident A for two years. Employee #1 stated she had provided care for Resident A on the night shift for approximately one year and now worked on the day shift. Employee #1 stated Resident A had "some memory issues" in which she would sometimes need reminders to take her dog outside. Employee #1 stated Resident A ambulated independently without equipment, was a standby assist for showering and was mostly independent with her activities of daily living. Employee #1 stated she was only aware of one other time when Resident A had a period of confusion on night shift which was on 12/20/2022. Employee #1 stated the observation report read Resident A was out of bed at 1:00 AM on 12/20/2022 in which she wanted breakfast and staff assisted her back to bed. Employee #1 stated Resident A's daughter had taken her to the urgent care for evaluation sometime that same week. Employee #1 stated on 12/23/2022 when Resident A was discovered outside, she was fully dressed and had her coat on, but was without her dog. Employee #1 stated she observed Resident A's apartment in which her dog was not locked in the kennel and the dog had defecated all over the room, which was unlike Resident A to have not placed the dog in kennel for the night. Employee #1 stated staff were required to check on residents every two hours throughout the day and night in which not all staff followed that policy. Employee #1 stated if a resident had a change in condition, then the caregiver or medication

technician would complete an observation report in which would then be reviewed by the Director of Health and Wellness for follow up.

While on-site, I interviewed Executive Director Dollie Duckworth who stated the facility did not have cameras inside or outside. Ms. Duckworth stated residents wore pendants and if the pendant was pushed, staff were alerted on their pagers. Ms. Duckworth stated two staff, Employee #3 and Employee #4, were on duty on 12/23/2022 and were assisting other residents who had pushed their call pendants when Resident A likely exited the facility. Ms. Duckworth stated Employee #3 had re-hired with the facility on 10/5/2022.

While on-site, I interviewed Employee #2 who stated staff, both medication technicians and caregivers, completed observation reports in the computer system in which she would review, then reassess the resident and update the service plan if needed.

While on-site, I interviewed the maintenance director who stated the facility's doors remain unlocked until 9:00 PM in which at that time, all doors locked from the outside until 6:00 AM, except for the facility's first main entrance sliding door. The maintenance director stated each of the locked doors have a doorbell on the outside which connect to the staff's pager if pushed. The maintenance director stated resident's pendants could be utilized outside the facility.

While on-site, I observed two hallway exit doors, one exited to the south back parking lot of the facility, and one exited to the north of the facility towards the driveway, in which each had a doorbell outside. I observed the area outside of the north door exit and across the driveway which was lined with snow fencing. I observed the location across the driveway near the snow fencing where Resident A was found by the snowplow driver. I observed Resident A's apartment in which there was a sign on the wall which read:

Walk Buttercup

- *When you wake up*
- *10:00 morning*
- *12:00 noon (Before lunch)*
- *2:30 afternoon (Before Bingo)*
- *5:00 evening (Before Dinner)*
- *7:00 evening*
- *9:00 (Before bed)*

While on-site, I reviewed Employee #3 and #4's employment files with Ms. Duckworth. Ms. Duckworth stated Employee #3 was a re-hire on 10/5/2022 in which previous orientation and training records would need to be retrieved from a file in the facility basement. Ms. Duckworth stated Employee #4 was recently hired.

On 1/4/2023, I conducted a second on-site inspection of the facility. I interviewed newly appointed administrator Tina Brindley who stated Employee #4 had completed her training and was working independently on third shift on 12/22/2022. Ms. Brindley stated she had worked previous shifts in that building; however, it was her first time working third shift.

While on-site, Ms. Brindley and I reviewed the resident census from 12/1/2022 through 12/16/2022, in which there were 20 residents in the facility. The census read from 12/17/2022 through 12/23/2022, there were 21 residents in the facility. Ms. Brindley stated there were two residents who required two-person assistance, and one other resident who sometimes required two-person assistance.

While on-site, I interviewed Employee #1 whose statements were consistent with Ms. Brindley. Employee #1 stated she could not recall if Resident A was wearing her pendant or not the morning she was discovered outside of the facility, however she was informed from the maintenance director that it was with her family at the funeral home, so it was assumed she was wearing it in the morning hours of 12/23/2022 and it was on her person when she was transported by the ambulance to the hospital.

While on-site, I reviewed the staff schedule dated 12/1/2022 through 12/23/2022. The schedule read there were three shifts, 7:00 AM to 3:00 PM, 3:00 PM to 11:00 PM and 11:00 PM to 7:00 AM in which the medication technicians arrived 15 minutes early for their shifts. The schedule read Employees #3 and #4 were on duty. The schedule read for third shift, there were two staff assigned, one medication treatment professional (MTP) and one personal wellness partner (PWP) for all dates except 12/15/2022 in which there were two MTPs and one PWP who worked.

While on-site, I reviewed Employee #4's Paychex timecard which read she had worked a single shift on 12/7/2022 and 12/9/2022, two shifts on 12/10/2022 and 12/12/2022, and a single shift on 12/13/2022, 12/19/2022, and 12/22/2022.

While on-site, I interviewed Employee #5 who scheduled staff at the facility in which she stated the facility recently changed their staffing to one MTP and two PWPs on duty for each shift. Employee #5 stated she tried to consistently schedule staff to the same building on campus, however, all staff were trained in each building which maintained three licensed Adult Foster Care (AFC) homes and one licensed Home for the Aged (HFA). Employee #6 stated staff worked three to five days in training, then could work independently or could extend their training if needed. Employee #5 stated although the schedule had not read Employee #4's training dates, except for 12/7/2022, she had completed training and was working independently on 12/22/2022. Employee #5 stated staff scheduled to work the HFA remained within that facility throughout their entire shift.

While on-site, Ms. Brindley and I tested the doorbells at the front entrance, as well as both north and south exit doors. All three doorbells appropriately alerted Employee #1's pager. Additionally, Ms. Brindley and I tested room 13's pendant outside the north and south exit doors and it appropriately alerted Employee #1's pager. Since the previous

inspection, the north and south exit doors have an alarm system which would activate when the doors are opened after they are automatically locked at 9:00 PM thereby alerting staff of someone exiting the facility.

I reviewed Resident A's face sheet which read in part she admitted to the facility on 4/19/2021 and Relative A1 was her activated power of attorney for health care. The face sheet read in part Resident A's diagnoses were dementia, major depressive disorder, anxiety disorder, Alzheimer's disease, unspecified visual disturbance, unspecified hearing loss, essential (primary) hypertension, chronic kidney disease, unspecified abnormalities of gait and mobility, abnormal weight gain, and need for assistance with personal care.

I reviewed Resident A's admission contract dated 4/14/2021 and noted it was signed by Resident A.

I reviewed Resident A's service plan updated on 11/30/2022 which read consistent with statements from Employee #1. The plan read in part Resident A was alert and oriented, as well as alert to her surroundings. The plan read in part Resident A displayed positive/appropriate interactions with others and required no assistance. The plan read in part Resident A walked her dog daily.

I reviewed Resident A's observation notes dated from 12/1/2022 through 12/24/2022.

> Note dated 12/20/2022 read in part Resident A was observed at about 12:00 AM coming out of her room and wanting to go to breakfast in which staff explained it was not time and escorted her back to her room. The note read in part Resident A was observed a second time out of her room and asking for breakfast. Staff then checked Resident A's clocks to ensure they were correct which they were and noted Resident A to be confused on the time.
>
> Note dated 12/21/2022 read in part Resident A tested negative for COVID. The note read in part Resident A's family transported her to the urgent care for a sore throat in which she was tested for strep throat, COVID, flu and respiratory syncytial virus (RSV). The note read in part the strep throat culture came back negative, but the other three test results were pending.
>
> Note dated 12/22/2022 read in part Resident A's three pending tests came back negative. The note read in part for staff to please keep an eye on Resident A and ask her how she is feeling the next few days.
>
> Note dated 12/23/2022 and completed by Employee #3 read in part Resident A came out of her room and wanted to outside to get a bird in which staff re-directed her. The note read in part around 3:15 AM Resident A came out of her room a second time in which staff escorted her back then both staff members on duty went to assist another resident. The note read in part she believed Resident A went outside around 4:30 AM.

I reviewed the facility's hourly summary report for call light pendants dated 12/23/2022 from 1:00 AM through 8:00 AM which read Resident A had not utilized her call pendant. The report read consistent with Ms. Duckworth's interview in which there were three call pendants pushed during the hours of both 3:00 AM and 4:00 AM.

I reviewed the facility's policy titled *Basic Care Services* which read in part:

> *Each Community Member is monitored on a routine basis.*

I reviewed the facility's policy titled *Team Member Monitoring/Observations* which read in part:

> *PURPOSE:*
> *Team members shall monitor for changes in the status of Community Members and report and document such changes according to established PROCEDUREs and in a timely manner.*
>
> *PROCEDURE:*
> 1. *Employees shall observe for changes in the status of Community Members.*
> 2. *Examples of changes that team members may observe include:*
>   - *A change in mood, emotion, or daily habits*
>   - *A change in sleep pattern*
> 3. *Team members shall report any changes to the Health and Wellness Director or designee and document on the Daily Report to Manger. When team members report changes in a Community Member's condition, Health and Wellness Director or designee shall determine what action should be taken. Interventions that might be appropriate include:*
>   - *Ongoing observation/ monitoring by team members.*

I reviewed Employee #3's file which read she completed a medication competency evaluation on 10/19/2022.

I reviewed Employee #4's file which she was hired on 12/7/2022 and her Workforce Background Check dated 11/29/2022 read she was eligible for hire. The file read Employee #4 had received training on the following topics but not limited to: a general orientation competency evaluation which included resident abuse and neglect, the Employee Handbook, Resident's Rights and Responsibilities, the incident report form, the Stop and Watch form, and the elopement and missing community member policies.

I reviewed police report #22-00853 dated 12/23/2022 at 7:09 AM which read in part:

> *"I spoke with caregiver [Employee #3] who explained she was new to working in the facility. [Employee #3] was working the midnight shift at Timber Ridge on 12/22/2022 into 12/23/2022. [Employee #3] explained at approximately 0300*

hours she heard footsteps in the hallway near the office, which is also near the north exit door. [Employee #3] explained she observed [Resident A] attempting to leave the facility through the north exit door. [Employee #3] stated [Resident A] was trying to get a bird that she had observed outside. [Employee #3] stated she took [Resident A] back to her room and got her back in bed. According to [Employee #3] she "completed her rounds" every hour after returning [Resident A] to her room. This contradicts [Employee #1]'s statement indicating [Employee #3 and #4] did not check on the residents like they are supposed to every two hours. [Employee #3] advised me herself and [Employee #4] had to assist room 14's resident with a mess they had made. [Employee #3] stated when the two were in room 14 cleaning up the mess is when [Resident A] most likely left. According to [Employee #3], this was at 0400 because she has to complete her vital check/rounds every hour. However, if [Employee #3] needed to complete her rounds every hour, she would have checked on [Resident A] and observed she was missing after they had finished up cleaning the mess in room 14. This indicated to me that [Resident A] was not checked on for at least 3-4 hours prior to being discovered outside."

At the time of the investigation, the Resident A's cause and manner of death were still pending test results.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.
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:	Review of Resident A's medical record revealed she had a diagnosis of Alzheimer's dementia in which she required reminding from staff. Review of observations notes revealed Resident A had a recent change in her sleep patterns and cognition in which it was requested for her to have increased monitoring by staff. Staff attestations revealed staff were to conduct routine checks on residents. However, from 3:15 AM to 7:00 AM Resident A was not observed by staff, thus she lacked safety and protection. Based on this information, this violation was substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Resident A's service plan updated on 11/30/2022 read she was alert and orientated, as well as alert to her surroundings.

Resident A's observation notes dated 12/20/2022 revealed she had change in her sleep pattern and confusion.

The facility's policy titled *Team Member Monitoring/Observations* read in part:

PURPOSE:
Team members shall monitor for changes in the status of Community Members and report and document such changes according to established PROCEDUREs and in a timely manner.

PROCEDURE:
1. *Employees shall observe for changes in the status of Community Members.*
2. *Examples of changes that team members may observe include:*
    - *A change in mood, emotion, or daily habits*
    - *A change in sleep pattern*
3. *Team members shall report any changes to the Health and Wellness Director or designee and document on the Daily Report to Manger. When team members report changes in a Community Member's condition, Health and Wellness Director or designee shall determine what action should be taken. Interventions that might be appropriate include:*
    - *Ongoing observation/ monitoring by team members.*

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(5) A home shall update each resident's service plan at least annually or if there is a significant change in the resident's care needs. Changes shall be communicated to the resident and his or her authorized representative, if any.
For Reference R 325.1901	**Definitions.**
	(21) "Service plan" means a written statement prepared by the home in cooperation with a resident and/or the resident's authorized representative or agency responsible for a resident's placement, if any, and that identifies the specific care and maintenance, services, and resident activities appropriate for each individual resident's physical, social, and behavioral needs and well-being and the methods of providing the care and services while taking into account the preferences and competency of the resident.
ANALYSIS:	Review of Resident A's medical records revealed she had diagnosis of Alzheimer's dementia. Observation notes revealed Resident A had a change in her sleep pattern and orientation to time, as well as situation. Review of the facility's policy revealed Resident A's service plan lacked specific guidance and methodology for staff to monitor her sleep patterns and orientation. Based on this information, a violation was substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 12/27/2022, interview with Ms. Duckworth revealed Employee #3 was previously hired with the facility, then re-hired on 10/5/2022. Ms. Duckworth and Employee #5 stated part of Employee #3's file was in the basement of the facility in which they would need additional time to retrieve. At the time of inspection, Employee #3's file read she had received Resident Rights training on 7/4/2021, signed her job description as a Medication and Treatment Professional on 9/30/2022, completed a medication competency evaluation on 10/19/2022 and CPR/First Aide training on 10/28/2022.

On 12/29/2022, Ms. Brindley submitted additional records from Employee #3's file to the department. The records read Employee #3 was originally hired 10/1/2020 at Vista Springs Edgewood as culinary services concierge. The records read on 10/1/2020 Employee #3 received training for the community member suspected abuse policy, the employee handbook, photographing residents' policy, as well as other training pertaining to employment specific to the company. Additionally, the records read Employee #3's general orientation checklist was signed and dated on 12/29/2022. A Workforce Background Check dated 12/29/2022 read Employee #3 was eligible for hire.

Review of Resident A's admission contract revealed in part:

Required staff training included:

a. *Reporting requirements of suspected abuse, neglect, or exploitation of vulnerable adults*
b. *CPR and First Aid*
c. *Personal Care*
d. *Resident Rights and Responsibilities*
e. *Safety and Fire Prevention*
f. *Containment of infectious diseases and standard precautions*
g. *Medication Administration (only staff designated to administer medications)*
h. *Disaster Preparedness, including Fire, Explosion, Loss of Heat, Loss of Power, Loss of Water, Weather Emergencies and Active Shooter*

Staff competencies are observed, recorded and a training checklist will be maintained in each employee file.

APPLICABLE RULE	
MCL 333.20173a	**Covered facility; conditions of continued employment**
	(2) Except as otherwise provided in this subsection or subsection (5), a covered facility shall not employ, independently contract with, or grant privileges to an individual who regularly has direct access to or provides direct services to patients or residents in the covered facility until the covered facility or staffing agency has a criminal history check conducted in compliance with this section or has received criminal history record information in compliance with subsections (3) and (10).
For Reference: R 325.1944	**Employee records and work schedules.**

	Rule 44. (1) A home shall maintain a record for each employee, which shall include all of the following: **(a) Name, address, telephone number, and social security number.** **(b) License or registration number, if applicable.** **(c) Date of birth.** **(d) Summary of experience, education, and training.** **(e) Beginning date of employment and position for which employed.** **(f) References, if provided.** **(g) Results of initial TB screening as required by R 325.1923(2).** **(h) Date employment ceases and reason or reasons for leaving, if known.** **(i) Criminal background information, consistent with section 20173a, MCL 333.20173a, of the code.**
ANALYSIS:	Review of Employee #3's file read she was hired initially in the culinary department at another facility within the company on 10/1/2020, then re-hired to Vista Springs Imperial Park at Timber Ridge as a Medication Technician and Treatment Professional on 10/5/2022. Employee #3's file lacked records consistent with the facility's policy including a checklist demonstrating training for personal care, safety and fire prevention, containment of infectious diseases and standard precautions, as well as disaster preparedness. Additionally, in accordance with this rule, Employee #3's file lacked record of a criminal background check upon her re-hire date of 10/5/2022, as well as the date her employment ceased with reasons. Based on this information, the facility was not in compliance with their policy and this rule.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **[For reference: see Licensing Study Report (LSR) AH190401909_RNWL_20210414 dated 4/14/2021, CAP dated 5/3/2021]**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 12/27/2022, review of Employee #3's file revealed it lacked the facility's general orientation competency staff training checklist.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(6) The home shall establish and implement a staff training program based on the home's program statement, the residents service plans, and the needs of employees, such as any of the following: **(a) Reporting requirements and documentation.** **(b) First aid and/or medication, if any.** **(c) Personal care.** **(d) Resident rights and responsibilities.** **(e) Safety and fire prevention.** **(f) Containment of infectious disease and standard precautions.** **(g) Medication administration, if applicable.**
ANALYSIS:	The facility was unable to demonstrate Employee #3 received training and competency in personal care, safety and fire prevention, containment of infectious disease and standard precautions upon her re-hire date of 10/5/2022 as a Medication Technician and Treatment Professional.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **[For reference: see Licensing Study Report (LSR) AH190401909_RNWL_20210414 dated 4/14/2021 with Corrective Action Plan (CAP) dated 5/3/2021 and Special Investigation Report (SIR) AH190401909_SIR_2021A1021048 dated 10/19/2021 with CAP dated 11/8/2021]**

IV. RECOMMENDATION

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

12/29/2022

Jessica Rogers Date
Licensing Staff

Approved By:

01/20/2023

_____

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