STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

February 2, 2023

Louis Andriotti, Jr.
IP Vista Springs Trillium Village OpCo
2610 Horizon Dr. SE, Suite 110
Grand Rapids, MI 49546

RE: License #: AH630401935
Investigation #: 2023A1019007
Vista Springs Trillium Village Estate

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. Failure to submit an acceptable corrective action plan will result in disciplinary action. 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.

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,

Elizabeth Gregory-Weil, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 347-5503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH630401935
Investigation #:	2023A1019007
Complaint Receipt Date:	12/21/2022
Investigation Initiation Date:	12/21/2022
Report Due Date:	02/20/2023
Licensee Name:	IP Vista Springs Trillium Village OpCo
Licensee Address:	2610 Horizon Dr. SE, Suite 110 Grand Rapids, MI 49546
Licensee Telephone #:	(616) 259-8659
Administrator:	Tina Brindley
Authorized Representative:	Louis Andriotti, Jr.,
Name of Facility:	Vista Springs Trillium Village Estate
Facility Address:	6800 Trillium Dr Clarkston, MI 48346
Facility Telephone #:	(248) 878-5266
Original Issuance Date:	01/21/2020
License Status:	REGULAR
Effective Date:	07/21/2022
Expiration Date:	07/20/2023
Capacity:	99
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Facility staff don't wear masks.	No
Medications are unsecured.	No
Staff aren't bathing Resident A.	No
Resident A's sheets aren't washed.	No
The facility is dirty.	No
Additional Findings	Yes

III. METHODOLOGY

12/21/2022	Special Investigation Intake 2023A1019007
12/21/2022	Special Investigation Initiated - Letter Emailed administrator for information.
12/22/2022	Contact - Document Received Requested information received from the AR.
12/22/2022	APS Referral Notified APS of the allegations via email referral template.
12/28/2022	Inspection Completed On-site
12/28/2022	Inspection Completed BCAL Sub. Compliance

The complainant identified some concerns that were not related to licensing rules and statutes for a home for the aged. Therefore, only specific items pertaining to homes for the aged provisions of care were considered for investigation. The following items were those that could be considered under the scope of licensing.

ALLEGATION:

Facility staff don't wear masks.

INVESTIGATION:

On 12/21/22, the department received a complaint that facility staff don't wear masks properly resulting in an increase in COVID cases. Due to the anonymous nature of the complaint, I was unable to obtain any additional information.

On 12/28/22, I conducted an onsite inspection. I interviewed Employee A at the facility. Employee A provided me with a copy of the facility's healthy and wellness policy on mask wearing during the COVID-19 pandemic. The policy read, in part "Community members, staff, and visitors are required to wear a mask when there is noted high transmission rates in the county or during an active period in the community." The policy defined an active period as "having one or more case of COVID-19 among community members in the facility". Employee A stated that the last COVID + resident case at the facility occurred on 11/8/22 and only affected one resident. Employee A stated that even though the facility is not currently in an active period, all staff are required to wear masks and that staff are compliant with that expectation. While onsite, I walked the entire building and noted that all staff observed (no less than eleven employees) were wearing masks.

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.**
ANALYSIS:	Review of facility policy combined with direct observation of staff reveal that masks are being worn in the facility.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Medications are unsecured.

INVESTIGATION:

The complaint alleged that staff leave medications unattended. The complaint did not identify any staff names or dates that this allegedly occurred on, and no additional information was provided. I interviewed Employees A and B regarding medication procedures. Employees A and B both attested that medication carts are kept in locked medication rooms which only limited staff can access. While touring the facility, I noted that med carts were properly stored in the medication rooms. I did not see any medications left out and unattended. I also directly observed multiple resident rooms and did not see any medications left out.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(5) A home shall take reasonable precautions to ensure or assure that prescription medication is not used by a person other than the resident for whom the medication is prescribed.
ANALYSIS:	Based on staff interviews and direct observation, I am unable to substantiate this allegation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Staff aren't bathing Resident A.

INVESTIGATION:

The complaint alleged that Resident A is not cleaned; no additional detail was provided. Employee B reported that Resident A is bed bound and requires two to three staff for transfer assistance and uses a hoyer lift. Employee B stated that due to Resident A's size and limited mobility, he receives bed baths. Employee B stated that Resident A is very compliant with care and can verbalize his needs.

While onsite, I reviewed Resident A's service plan which identified Monday, Wednesday and Fridays as his assigned bathing days. Following review of his service plan, I interviewed Resident A directly. Resident A confirmed that he

receives bed bathes and stated “they bathe me damn near everyday”. Resident A denies being unclean and stated that staff are attentive to his bathing needs. I found Resident A to be a credible historian and was fully alert and oriented.

APPLICABLE RULE	
R 325.1933	**Personal care of residents.**
	(2) A home shall afford a resident the opportunity and instructions when necessary for daily bathing, oral and personal hygiene, daily shaving, and hand washing before meals. A home shall ensure that a resident bathes at least weekly and more often if necessary.
ANALYSIS:	Resident A’s service identifies that he is to bathe three times weekly, however Resident A stated himself that he is bathed more frequently.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A’s sheets aren’t washed.

INVESTIGATION:

The complaint alleged that Resident A is left in a dirty bed; no additional detail was provided. Employees A and B reported that laundry is done on assigned shower days and more often as needed. Employee B stated that staff apply powder and ointment to Resident A’s legs, which can get messy and does require frequent bedding and sheet changes.

Resident A’s service plan reads that his laundry should be completed on Monday, Wednesday, and Friday during the midnight shift. Employee A provided me with a task administration record where staff are expected to document when laundry is completed. Review of the log for the previous four-week period reveals that laundry is completed consistent with the frequency outlined in his service plan. Resident A himself stated that facility staff do his laundry three to four times weekly and change his sheets at least twice weekly.

APPLICABLE RULE	
R 325.1935	**Bedding, linens, and clothing.**
	(1) Bedding shall be washable, in good condition, and clean, and shall be changed at least weekly or more often as required.
ANALYSIS:	Resident A's service identifies that his laundry is done three times a week. Resident A confirmed that this occurs and stated himself that his sheets are changed more often than weekly and this rule requires.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The facility is dirty.

INVESTIGATION:

The complaint alleged that the facility is not cleaned; no additional detail was provided.

Employee A stated that the facility has a full-time housekeeper and that there is a cleaning schedule that the housekeeper follows. During my onsite visit, the housekeeper was not working, however employee A provided me with a copy of the cleaning schedule. The schedule identified that the second floor is cleaned on Mondays, memory care even numbered rooms are cleaned on Tuesdays, the third floor is cleaned on Wednesdays and memory care odd numbered rooms are cleaned on Thursdays. In addition to the cleaning schedule, Employee A stated that garbage is emptied and removed from the facility daily.

While onsite, I walked through the entire facility and noted it to be clean and in good repair. In addition to common areas, I went into nine resident rooms and interviewed five residents regarding the cleanliness of the facility. All residents interviewed denied any issues with facility housekeeping or overall cleanliness of the facility.

APPLICABLE RULE	
R 325.1979	**General maintenance and storage.**
	(1) The building, equipment, and furniture shall be kept clean and in good repair.

ANALYSIS:	Review of the cleaning schedule along with interviews with residents reveal that the facility has a organized cleaning protocol. Direct observation of common areas and resident rooms showed all areas to be clean and in good condition.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

At the time this intake was received, the administrator on file was listed as Employee C, but attempts to reach Employee C went unanswered. Licensing staff reached out to authorized representative Lou Andriotti who reported that Employee C had not been with the organization since 10/10/2022 and stated that Employee D was going to be appointed as the administrator. At the time of my onsite inspection, a new administrator appointment form had not been submitted and when licensing staff went onsite to the facility on 12/28/22, Employee A reported that she was the administrator. Following my onsite visit, Mr. Andriotti submitted a BCAL 1606 form (administrator appointment document) and resume for Employee E. From 10/10/22-12/28/22, the facility had an appointed administrator on file who no longer worked at the facility.

APPLICABLE RULE	
R 325.1913	**Licenses and permits; general provisions.**
	(2) The applicant or the authorized representative shall give written notice to the department within 5 business days of any changes in information as submitted in the application pursuant to which a license, provisional license, or temporary nonrenewable permit has been issued.
ANALYSIS:	The facility failed to provide timely notification and submit documentation when a change of administrator occurred.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon approval or an acceptable corrective action plan, I recommend no changes to the status of the license at this time.

01/03/2023

Elizabeth Gregory-Weil — Date
Licensing Staff

Approved By:

02/02/2023

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