GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 25, 2023

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

RE: License #: AL190383347
Investigation #: 2023A0783008
Vista Springs Terraces 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 responsible party and a date.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (517) 284-9730.

Sincerely,

Leslie Herrguth, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 256-2181

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL190383347
Investigation #:	2023A0783008
Complaint Receipt Date:	12/02/2022
Investigation Initiation Date:	12/02/2022
Report Due Date:	01/31/2023
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:	Louis Andriotti, Jr.
Licensee Designee:	Louis Andriotti, Jr.
Name of Facility:	Vista Springs Terraces at Timber Ridge
Facility Address:	16260 Park Lake Road East Lansing, MI 48823
Facility Telephone #:	(517) 339-2322
Original Issuance Date:	11/14/2016
License Status:	REGULAR
Effective Date:	05/14/2021
Expiration Date:	05/13/2023
Capacity:	20
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A's medications were deliberately not administered to Resident A by staff members due to unpaid bills.	No
Resident A's medication was not administered as prescribed from July 2022 – December 2022.	Yes

III. METHODOLOGY

12/02/2022	Special Investigation Intake - 2023A0783008
12/02/2022	Special Investigation Initiated – Telephone call with Complainant
12/02/2022	APS Referral not needed as APS already involved
12/02/2022	Contact - Document Received - Pharmacy bill for Resident A
12/09/2022	Inspection Completed On-site
12/09/2022	Contact - Face to Face interviews with direct care staff member Tameka Allen and Resident A
12/09/2022	Contact - Document Received - Resident A's medication administration records (MARs)
12/09/2022	Contact - Telephone call made to direct care staff member Cassandra Jarrell
12/12/2022	Contact - Telephone call made to Tameka Allen
12/12/2022	Contact - Telephone call made to facility manager Dollie Duckworth
12/12/2022	Contact - Telephone call made to former facility manager Jenny Bishop
12/16/2022	Contact - Telephone call made to Dollie Duckworth
12/16/2022	Contact - Telephone call made to licensee designee Lou Andriotti
12/29/2022	Contact - Telephone call made to Lou Andriotti

12/29/2022	Contact - Telephone call made to senior operations support executive Liz Coffelt
01/25/2023	Exit Conference with Lou Andriotti

ALLEGATION:

- **Resident A's medications were deliberately not administered to Resident A by staff members due to unpaid bills.**

- **Resident A's medication was not administered as prescribed from July 2022 – December 2022.**

INVESTIGATION:

On December 2, 2022, I received a complaint via centralized intake that stated the direct care staff members at the facility withheld Resident A's blood pressure medication from July 2022 – December 2022 because Resident A would not pay her pharmacy bill nor her room and board at the facility.

On December 2, 2022, I spoke with Complainant who said facility staff members withheld Resident A's blood pressure medication from July 2022 – December 2022 because Resident A would not pay her room and board payment at the facility. Complainant said staff members claimed Resident A's medication was not given because it was not available due to an unpaid pharmacy bill. Complainant said Resident A told him on November 17, 2022, that a staff member showed Resident A the medication and told her it could not be administered. Complainant said direct care staff member Tameka Allen told him that Resident A's blood pressure medication was in a locked office and put back in the medication cart on November 16, 2022. Complainant said no reason was provided as to why Resident A's medication was in an unoccupied locked office from July 2022 – November 16, 2022. Complainant stated he reviewed the medication cart in June 2022 and verified Resident A's medication was not there, and he recently visited the facility again and Resident A's prescribed medication was in the medication cart. Complainant said Resident A does have an outstanding pharmacy bill and Hometown Pharmacy will not refill the medication until Resident A pays the bill which she has refused to do. Complainant said Resident A does not have a guardian nor conservator and that at this time she makes her own financial decisions.

On December 2, 2022, I received and reviewed a bill from Hometown Pharmacy addressed to Resident A in the amount of $404.87 and dated July 31, 2022. The bill stated it must be paid to avoid paying cash upon delivery of any further medication refills.

On December 9, 2022, I completed an unannounced onsite investigation at the facility and reviewed Resident A's medication administration record (MAR) and Resident A's medication at the facility. Resident A had Lisinopril 20 MG tablets to be taken once daily. I noted that the prescription was filled on January 6, 2022. I noted that someone wrote "Destroy" and "Expired" on the medication and then crossed it off. Resident A's MAR was reviewed from June 2022 – December 2022. I noted that from June 21, 2022, until December 9, 2022, Resident A's prescribed Lisinopril was not administered. According to the written MARS the medication was not administered due to "no med," "med not available," "no medication available, resident still owes the pharmacy," "medication not available at this time to pass. Outstanding bill with the pharmacy that has yet to be paid."

On December 9, 2022, I interviewed Resident A who said, "my rent doesn't have anything to do with my medication." Resident A denied that any staff member ever showed her a pack of blister pills belonging to Resident A nor did any person affiliated with the facility tell her nor provide anything in writing indicating that Resident A's medication would not be administered until her room and board payments were current.

On December 9, 2022 and December 12, 2022, I interviewed direct care staff member Tameka Allen who stated she administers medication at the facility as part of her job responsibilities. Ms. Allen stated beginning in June 2022 Resident A's prescribed medication was "missing" and the medication "mysteriously" appeared back in the medication cart on November 16, 2022. Ms. Allen said when the bubble pack of medication was placed back in the medication cart someone wrote "destroy" and "expired" on the medication. Ms. Allen stated she noted that according to the medication label it did not expire until January 2023. Ms. Allen said when she found the pills on November 16, 2022, she texted facility managing partner Dollie Duckworth who informed her that she found the pills in an unoccupied office and was told they were expired. Ms. Allen said she informed Ms. Duckworth that the medication was not expired, and she put it back in the medication cart. Ms. Allen said she and her coworkers believed Resident A did not have medication at the facility due to an unpaid pharmacy bill. Ms. Allen stated she was not aware that Resident A was also behind on her room and board payments. Ms. Allen stated when the now unoccupied office where Resident A's medication was found belonged to former health and wellness director Cassandra Jarrell who worked as the health and wellness director in that office from June – August 2022. Ms. Allen stated the management team in charge at the time the medication was removed from the medication cart are no longer employed at the facility.

On December 9, 2022, I spoke to direct care staff member Cassandra Jarrell who said she worked as the health and wellness director from June – August 2022 and then requested to be demoted back to a medication technician which is her current position at the facility. Ms. Jarrell stated she was aware that Resident A was late and then refused to pay her room and board payment, but she was never told to withhold Resident A's medication, nor did she make that decision on her own. Ms. Jarrell

stated she occupied the now unoccupied office where Resident A's medication was found but she never saw, nor did she put Resident A's medication in that office. Ms. Jarrell said from June – August 2022 she made efforts to get the medication for Resident A but there was no medication for Resident A at the facility due to an unpaid pharmacy bill. Ms. Jarrell said she contacted the pharmacy and Resident A's physician on her behalf but was unable to get the medication because Resident A would not pay the outstanding pharmacy bill.

On December 12, 2022, I spoke to current facility manager Dollie Duckworth who said she has been in her current position since October 2022. Ms. Duckworth denied finding medication for Resident A in an unoccupied office in the facility. Ms. Duckworth stated she was never approached by any staff member at the facility to inform her that Resident A's medication was not at the facility. Ms. Duckworth denied any knowledge of Resident A having an outstanding balance with the pharmacy nor with the facility.

On December 16, 2022, I spoke with Ms. Duckworth a second time and she stated she now recalled that in November 2022 she found Resident A's medication in an unoccupied office in the facility and she returned the blister pack to the medication cart after writing "destroy" and "expired" on the medication package. Ms. Duckworth stated no staff member could explain why the medication was in the unoccupied office, but one person told her they thought the medication was expired. Ms. Duckworth said she did not recall looking for the expiration date on the medication label but assumed it was expired and placed it back in the medication cart to be destroyed.

On December 12, 2022, I spoke to former facility administrator Jenny Bishop who stated she worked at the facility in June 2022 and that she chose to terminate her employment at the facility in September 2022. Ms. Bishop stated Resident A's medication was not at the facility for staff members to administer due to an unpaid pharmacy bill. Ms. Bishop stated the licensee paid for Resident A's medication on more than one occasion but ultimately the pharmacy required a credit or debit card be on file to fill the medication, which Resident A chose not to provide. Ms. Bishop denied any knowledge of how Resident A's medication was found in an unoccupied office within the facility. Ms. Bishop denied that she ever made the decision on her own nor was she directed to withhold Resident A's medication. Ms. Bishop denied that she placed Resident A's medication in the vacant office and denied knowing who did put the medication there.

On December 16, 2022 and December 29, 2022, I spoke to licensee designee Lou Andriotti who initially stated he was not aware that Resident A's medication was removed from the medication cart and the only concern he was aware of was that Resident A refused to take her medication. Mr. Andriotti denied ever making the decision nor giving the directive to remove Resident A's medication from the medication cart and withhold it from her for any reason. Mr. Andriotti said if a resident has an outstanding facility balance there are proper channels to go through

not involving the resident's medication and simply a financial discharge would be issued.

On December 29, 2022, I spoke to facility senior operations support executive Liz Coffelt who stated Resident A's medication was initially removed from the medication cart in July 2022 because Resident A refused to take the medication for more than 30 days. Ms. Coffelt stated she interviewed twelve facility medication technicians who all denied any knowledge of who removed Resident A's medication from the medication cart nor why, but all medication technicians were aware that Resident A's prescribed medication was not at the facility due to an unpaid pharmacy bill. Ms. Coffelt said multiple staff members told her that on or about November 16, 2022, Resident A's prescribed medication was located in an unoccupied office and placed back in the medication cart to administer to Resident A, which she again refused. Ms. Coffelt said Resident A's physician was notified and he discontinued the medication. Ms. Coffelt said Resident A's medication being removed from the medication cart had nothing to do with unpaid bills and the medications were removed simply because Resident A refused to take the medication.

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: (e) Not adjust or modify a resident's prescription medication without instructions from a physician or a pharmacist who has knowledge of the medical needs of the resident. A licensee shall record, in writing, any instructions regarding a resident's prescription medication.
ANALYSIS:	Based on statements from Ms. Allen, Resident A, Ms. Duckworth, Ms. Bishop, Ms. Jarrell, Mr. Andriotti and Ms. Coffelt there is lack of evidence to prove Resident A's medication was deliberately withheld from her for any reason. Rather, I determined Resident A in fact had an outstanding pharmacy bill in the amount of $404.87 so the medication could not be refilled. No interviews nor written documentation available suggested that Resident A's medication was purposefully withheld.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based on Resident A's written medication administration records and interviews with all involved, I determined Resident A's prescribed Lisinopril was not administered per the label directions nor at all from June 21, 2022 – December 9, 2022, because the medication was not available for staff members to administer. The investigation revealed someone removed Resident A's medication from the medication cart, though it was not determined who removed it, when it was removed, nor why, but regardless of those things Resident A did not get her medication as prescribed over the course of several months.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Leslie Herrguth 01/25/2023

Leslie Herrguth Date
Licensing Consultant

Approved By:

Dawn Timm 01/25/2023

Dawn N. Timm Date
Area Manager