GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

December 11, 2023

Louis Andriotti, Jr.
Vista Springs Riverside Gardens LLC
2610 Horizon Dr. SE
Grand Rapids, MI 49546

RE: License #: AH410397993
Investigation #: 2024A1021014
Vista Springs Riverside Gardens

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) 284-9730.

Sincerely,
Kimberly Horst

Kimberly Horst, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH410397993
Investigation #:	2024A1021014
Complaint Receipt Date:	11/14/2023
Investigation Initiation Date:	11/17/2023
Report Due Date:	1/14/2023
Licensee Name:	Vista Springs Riverside Gardens LLC
Licensee Address:	Ste 110 2610 Horizon Dr. SE Grand Rapids, MI 49546
Licensee Telephone #:	(616) 259-8659
Administrator/Authorized Representative:	Louis Andriotti, Jr.
Name of Facility:	Vista Springs Riverside Gardens
Facility Address:	2420 Coit Ave. NE Grand Rapids, MI 49505
Facility Telephone #:	(616) 365-5564
Original Issuance Date:	07/22/2020
License Status:	REGULAR
Effective Date:	01/22/2023
Expiration Date:	01/21/2024
Capacity:	70
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident has been left on commode and laid on the floor for hours.	No
Resident A received incorrect medication.	No
Additional Findings	Yes

III. METHODOLOGY

11/14/2023	Special Investigation Intake 2024A1021014
11/17/2023	Special Investigation Initiated - On Site
11/22/2023	Contact-Telephone call made Interviewed Wings of Hope hospice nurse
12/11/2023	Exit Conference

ALLEGATION:

Resident has been left on commode and laid on the floor for hours.

INVESTIGATION:

On 11/14/2023, the licensing department received a complaint from Adult Protective Services (APS) with concerns Resident A has been left on the commode and has fell and was left on the floor for hours. APS was not investigating the complaint.

On 11/17/2023, I interviewed staff person 1 (SP1) at the facility. SP1 reported Resident A has been a resident at the facility for approximately three weeks. SP1 reported a few weeks ago, Resident A pressed her call pendent for assistance to the bathroom and it took six minutes for staff to respond. SP1 reported the expectation is under 10 minutes. SP1 reported Resident A had a visitor and the visitor became very upset that it took too long for staff members to respond. SP1 reported she is only aware of one fall incident with Resident A and staff responded in a timely manner. SP1 reported if Resident A fell, she would be unable to get off the floor by herself. SP1 reported Resident A is hesitant to request staff assistance and the facility is working on encouraging Resident A to request help. SP1 reported Resident A is treated well at the facility.

On 11/17/2023, I interviewed SP2 at the facility. SP2 reported she was working the shift when Resident A fell. SP2 reported she was called into Resident A's room by another staff member. SP2 reported Resident A reported she was trying to transfer herself onto the commode and fell out of bed. SP2 reported Resident A did not complain of any pain or injuries. SP2 reported Resident A had not been on the floor for an extended period as Resident A was administered medication 30 minutes prior to staff finding Resident A on the floor.

On 11/22/2023, I interviewed Wings of Hope Hospice nurse Jenna Knowles by telephone. Ms. Knowles reported Resident A has had one fall at the facility because she attempted to self-transfer out of her bed. Ms. Knowles reported Resident A is very stubborn and will not request assistance. Ms. Knowles reported Resident A has stated staff members do not respond to her call pendent, but she has observed staff members checking on Resident A. Ms. Knowles reported she does not believe the facility is intentionally neglecting Resident A.

I reviewed call light response times for Resident A for 11/11-11/17. The average response time was 10 minutes which is within the expectation for the facility.

I reviewed observation report for Resident A. The report read,

> *"CM (community member) says she rolled over in bed and fell out of it. She says she scraped her nose on the ground when she fell and hit her knee. I asked CM if she had any other pain she said no only that her nose was sore. Vitals were good. Family HWD and doctor were all notified."*

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.**
For Reference: R 325.1921	**Definitions.**
	(p) "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:	Interviews conducted and review of documentation revealed lack of evidence to support the allegations.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A received incorrect medication.

INVESTIGATION:

APS received a complaint with concerns Resident A was administered Ativan medication four times in a day which caused her to black out.

SP1 reported the administration of medications have been difficult with Resident A. SP1 reported when Resident A admitted, Resident A was administering her own medications but not the narcotic medications. SP1 reported Resident A's physician and hospice company signed off that Resident A was competent to administer her own medications. SP1 reported it recently changed so that the facility is administering all Resident A's medications. SP1 reported the Ativan is prescribed for anxiety and restlessness on as needed basis. SP1 reported the order received is written oddly. SP1 reported Resident A can request this medication when she is feeling anxious. SP1 reported no knowledge of Resident A blacking out due to the medication.

I reviewed the medication administration record (MAR) for Resident A. The record revealed Resident A was prescribed Lorazepam 0.5mg tablet with instructions to administer one to four tablets by mouth every two hours as needed. The MAR revealed there was no instances of Resident A receiving four tablets of Lorazepam.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(2) Prescribed medication managed by the home shall be given, taken, or applied pursuant to labeling instructions, orders and by the prescribing licensed health care professional.
ANALYSIS:	Review of Resident A's MAR revealed lack of evidence to support the allegation Resident A was administered incorrect medication.

CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

SP2 and SP3 reported Resident A prefers to use the commode in the room and caregivers are not to leave Resident A unattended on the commode.

Resident A's service plan read,

> *"Provide assistance with toileting needs. Requires staff assistance with toileting needs."*

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.
ANALYSIS:	Interviews conducted revealed Resident A prefers to use the commode and staff members are not to leave Resident A unattended. Review of Resident A's service plan revealed lack of specific detail regarding Resident A's toileting needs and assistance.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

Review of Resident A's MAR revealed Resident A was prescribed Carbidopa-Levodopa 25-100mg with instruction to administer 1 ½ tablets by mouth Q2 hours while awake. There was no handwritten record of this medication 11/10-11/11.

APPLICABLE RULE	
R 325. 1932	**Resident's medications.**
	(2) Prescribed medication managed by the home shall be given, taken, or applied pursuant to labeling instructions, orders and by the prescribing licensed health care professional.

ANALYSIS:	Review of Resident A's MAR revealed staff are not administering medication as prescribed by the healthcare professional.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

SP1 reported with the change of management company the facility now has paper MAR's. SP1 reported it has been difficult to have a MAR for Resident A due to the changes in who administers the medications.

I reviewed Resident A's handwritten MAR for November 2023. The MAR revealed multiple medication dates and times in which staff did not initial when the medication was administered.

APPLICABLE RULE	
R 325. 1932	**Resident's medications.**
	(3) Staff who supervise the administration of medication for residents who do not self-administer shall comply with all of the following: **(v) The initials of the individual who administered the prescribed medication.**
ANALYSIS:	Review of Resident A's MAR revealed staff did not properly initial when medications were administered.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

Review of Resident B, Resident C, Resident D and Resident E November MAR revealed multiple instances in which staff members did not provide a record when a resident refuses a medication.

S4 reported with the facility transiting to paper MAR's, staff may not be aware they are to document a "R" in the record when a medication is refused.

APPLICABLE RULE	
R 325. 1932	**Resident's medications.**
	(3) Staff who supervise the administration of medication for residents who do not self-administer shall comply with all of the following: **(vi) A record if the resident refuses to accept prescribed medication and notification as required in subdivision (c) of this subrule.**
ANALYSIS:	Review of multiple resident's MARs revealed the facility does not record when a resident refuses a prescribed medication.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

Review of Resident A's MAR revealed Resident A was administered Lorazepam and Gabapentin medication on as needed basis. The MAR revealed caregivers did not record a reason for the administration of these medications.

APPLICABLE RULE	
R 325. 1932	**Resident's medications.**
	(3) Staff who supervise the administration of medication for residents who do not self-administer shall comply with all of the following: **(vii) A record of the reason for administration of a prescribed medication that is on an as-needed basis.**
ANALYSIS:	Review of Resident A's MAR revealed staff did not properly record the reason for the administration of the prescribed medication that is on an as-needed basis.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

11/22/2023

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Kimberly Horst Date
Licensing Staff

Approved By:

12/11/2023

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