GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

January 9, 2024

Louis Andriotti, Jr.
Vista Springs Wyoming LLC
Ste 110
2610 Horizon Dr. SE
Grand Rapids, MI 49546

RE: License #: AH410397992
Investigation #: 2024A1028009
Vista Springs Wyoming

Dear Louis 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 I am not available, and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

Julie Viviano, Licensing Staff
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

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

I. IDENTIFYING INFORMATION

License #:	AH410397992
Investigation #:	2024A1028009
Complaint Receipt Date:	10/24/2023
Investigation Initiation Date:	10/26/2023
Report Due Date:	12/23/2023
Licensee Name:	Vista Springs Wyoming LLC
Licensee Address:	Ste 110 2610 Horizon Dr. SE Grand Rapids, MI 49546
Licensee Telephone #:	(616) 259-8659
Administrator:	Jessica Hunter
Authorized Representative:	Louis Andriotti, Jr.
Name of Facility:	Vista Springs Wyoming
Facility Address:	2708 Meyer Ave SW Wyoming, MI 49519
Facility Telephone #:	(616) 288-0400
Original Issuance Date:	12/10/2019
License Status:	REGULAR
Effective Date:	06/10/2023
Expiration Date:	06/09/2024
Capacity:	147
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
The facility did not provide Resident A showers in a timely manner or in accordance with the service plan.	Yes
The facility did not provide medication administration in accordance with physician orders and the service plans to Resident A and Resident B.	Yes
Additional Findings	Yes

III. METHODOLOGY

10/27/2023	Special Investigation Intake 2024A1028009
11/1/2023	Special Investigation Initiated - Letter
11/08/2023	Contact - Face to Face Interviewed Employee A at the facility.
11/08/2023	Contact - Face to Face Interviewed Employee B at the facility.
11/08/2023	Contact - Face to Face Interviewed Employee C at the facility.
11/08/2023	Contact - Document Received Received Resident A's and Resident B's limited records from staff.

Intakes 198184 and 198310 were combined into one special investigation due to similar allegations and rule violations. Also, limited resident record information was obtained during this investigation due to the facility no longer having access to prior resident records as of 11/1/2023. The facility was cited for the record violation in special investigation 2024A1028008. Also, this investigation will only address potential violations pertaining to the rules and regulations for Homes of the Aged (HFA).

ALLEGATION:

The facility did not provide Resident A showers in a timely manner or in accordance with the service plan.

INVESTIGATION:

On 11/1/2023, the Bureau received the allegations through the online complaint system.

On 11/8/2023, I interviewed Employee A at the facility who reported Resident A has dementia with behaviors. Employee A reported Resident A does refuse showers intermittently and can be combative when care staff attempt to provide Resident A with a shower. Employee A reported care staff will approach a resident three times if a refusal is initially given for any care, but if the resident refuses three times, then it is documented, and the care is not provided. Employee A reported care staff understand that all residents have the right to refuse care. Employee A provided me Resident A's limited record for my review.

On 11/8/2023, I interviewed Employee B and Employee C at the facility whose statements were consistent with Employee A's statements.

On 11/8/2023, I completed an onsite inspection due to this investigation but was unable to observe Resident A due to being unavailable. However, other residents observed were groomed, content, and/or being assisted appropriately by care staff.

On 11/8/2023, I reviewed Resident A's record which revealed the following:

- Behaviors occurred on 9/28/2023, 10/6/23, 10/7/2023, 10/12/2023, 10/16/2023.
- Was given a shower on 10/22/2023.

On 11/8/2023, I requested Resident A's service plan with record, but the facility was unable to provide it due to no longer having access to prior resident records because of a management change on 11/1/2023.

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.

ANALYSIS:	It was alleged Resident A was not provided showers consistently with the service plan. The facility could not provide Resident A's service plan or any other documentation that demonstrated Resident A refused showers and/or that showers were provided in a timely manner or consistent with the service plan. Therefore, the facility is in violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

The facility did not provide medication administration in accordance with physician orders and the service plans to Resident A and Resident B.

INVESTIGATION:

On 11/8/2023, Employee A reported Resident A did receive routine blood sugar checks, but some were documented incorrectly by staff. The staff were re-educated on the importance of completing correct documentation. Employee A reported Resident A has refused blood sugar medication intermittently. Employee A reported the physician consistently communicates with the facility concerning Resident A's health and medication and the facility communicates with Resident A's family who is very involved as well. Employee A reported Resident B did not receive medication in a timely manner because the pharmacy entered the medication incorrectly into the pharmacy ordering system. Employee A reported [they] called the pharmacy to check on the medication Resident B required to get it filled. Employee A reported due to the new management entering the facility on 11/1/2023, the facility does not have access to the prior medication administration records (MAR) for any resident. The facility is currently using paper MARs to document medication administration. However, Employee A was able to provide me some documentation for Resident A and Resident B for my review.

On 11/8/2023, I reviewed Resident A's documentation which revealed the following:

- Resident A refused [their] Trulicity medication on three times on 10/6/2023 at 6:45am and again on 10/13/2023 at 10:15am.
- Evidence of some communication documented between physician and the facility concerning Resident A's blood sugar levels from 9/22/2023 to 10/12/2023.
- Resident A's blood sugar log from 9/22/2023 to 10/12/2023 showed blood sugars ranging from 90 to 430.
- Evidence of a medication order for insulin to be injected subcutaneously per a sliding scale three times daily before meals on 9/22/2023.
- Evidence of medication task documentation on 9/22/2023 to check blood sugar at scheduled times. Report blood sugar to physician or nurse

practitioner if blood is less than 80 or greater than 450. Provide snack according to designated scheduled and preference.
- On 10/2/2023, the medication order was edited to document the sliding scale parameters.
- On 10/24/2023, a medication task was documented to continue to check blood sugar and report blood sugar to physician or nurse practitioner if blood is less than 80 or greater than 450. Blood sugar checks are to occur before meals and nighttime.
- No medication administration record was provided to me for Resident A.

I reviewed Resident B's documentation which revealed the following:
- Resident B is a full code.
- Resident B is independent with dressing, eating, mobility and transfers.
- Requires supervision grooming, hygiene, and oral care.
- Resident B requires assistance from staff for bathing, toileting.
- The facility manages all medications.
- Requires 24-hour supervision, cannot make needs known, and requires frequent wellness checks from care staff for supervision and safety. Staff are to initial completion of wellness checks each shift.
- No medication administration record was provided to me for Resident B.

APPLICABLE RULE	
325.1932	**Resident Medications**
	(2) The giving, taking, or applying of prescription medications shall be supervised by the home in accordance with the resident's service plan.
ANALYSIS:	It was alleged Resident A's blood sugars were out of parameters and Resident A did not receive insulin in accordance with physician orders. It was alleged Resident B did not receive medication in a timely manner or in accordance with physician orders. Interviews and review of documentation reveal the facility has limited documentation in the record for both Resident A and Resident B resulting in no evidentiary support found that the facility provided medication in accordance with physician orders and the resident's service plans. Therefore, the facility is in violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

Additional Findings:

INVESTIGATION:

On 11/8/2023, I requested Resident A's service plan, and it could not be provided as requested due to the facility no longer having access to resident records prior to 11/1/2023.

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:	The facility was unable to provide a current and up to date service plan for Resident A when requested. Therefore, the facility is in violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 11/8/2023, it was discovered that staff documented Resident B's blood sugar incorrectly on the blood sugar log. Employee A reported staff received re-education on documenting correctly, but there is no evidence of staff re-education or training due to documentation errors.

APPLICABLE RULE	
R 325.1932	**Resident Medications.**
	(3) If a home or the home's administrator or direct care staff member supervises the taking of medication by a resident, then the home shall comply with all the of following provisions: **a. Be trained in the proper handling and administration of medication.**

ANALYSIS:	Interviews and review of documentation reveal Resident A's insulin was incorrectly documented on the blood sugar log and/or not documented at all. Staff were allegedly provided re-education and training on correct and appropriate documentation procedures when handling and administering medication. However, there is no evidence to support that staff were re-educated or re-trained appropriately. Therefore, the facility is in violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 11/8/2023, upon entrance to the facility, a Lidocaine patch was discovered on top of medication cart easily accessible to anyone in the facility. No care staff were present.

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:	Upon entering the facility, a Lidocaine patch was found on the medication cart easily accessible to anyone in the facility. Unsecured medications pose a potential risk of harm for residents. Therefore, the facility is in violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Julie Viviano

11/27/2023

Julie Viviano Date
Licensing Staff

Approved By:

01/09/2024

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