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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

January 25, 2024

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

RE: License #: AH410397993
Investigation #: 2024A1028016
Vista Springs Riverside Gardens

Dear Lou 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 #:	AH410397993
Investigation #:	2024A1028016
Complaint Receipt Date:	11/17/2023
Investigation Initiation Date:	11/22/2023
Report Due Date:	01/17/2024
Licensee Name:	Vista Springs Riverside Gardens LLC
Licensee Address:	Ste 110 2610 Horizon Dr. SE Grand Rapids, MI 49546
Licensee Telephone #:	(616) 259-8659
Authorized Representative/Administrator:	Louis Andriotti, Jr., Authorized Repr.
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?
Facility staff did not provide appropriate care for Resident A in a timely manner.	Yes
Resident A does not receive showers in accordance with the service plan.	Yes
Additional Findings	Yes

III. METHODOLOGY

11/17/2023	Special Investigation Intake 2024A1028016
11/22/2023	Special Investigation Initiated - Letter
11/22/2023	APS Referral No APS referral. APS made referral to HFA through Centralized Intake.
12/06/2023	Contact - Face to Face Interviewed Employee A at the facility.
12/06/2023	Contact - Face to Face Interviewed Employee B at the facility.
12/06/2023	Contact - Face to Face Interviewed Resident A at the facility.
12/06/2023	Contact - Document Received Received resident record and documentation from Employee A.

ALLEGATION:

Facility staff did not provide appropriate care for Resident A in a timely manner.

INVESTIGATION:

On 11/20/2023, the Bureau received the allegations through the online complaint system.

On 11/20/2023, Adult Protective Services (APS) made referral to Homes for the Aged (HFA) through Centralized Intake.

On 12/6/2023, I interviewed Employee A at the facility who reported Resident A had a prior fracture of the right leg due to a fall and was placed in an immobilizer. The exact date of the fall and of the immobilizer placement is unknown because the requested documentation could not be accessed by the facility staff. Employee A reported Resident A and facility staff were instructed by the physician to not remove the immobilizer. Employee A reported Resident A also refused to remove the immobilizer even when facility staff attempted to provide Resident A with a bed bath. Employee A reported staff are to approach three times when a resident initially refuses, but Resident A would not allow staff to touch the immobilizer out of fear of the fracture shifting. Employee A reported a home health agency was also seeing Resident A for decubitus ulcers on Resident A's bottom and observed new wounds on the right leg after removing the immobilizer on 11/16/2023 due to Resident A's complaint of pain. The home health nurse treated the new wounds and alerted facility staff and the physician about the new wounds. The facility was then directed by the home health agency to send Resident A to the hospital for further evaluation of the wounds. Resident A was sent to the hospital, and it was further noted that Resident A had bone exposure from the subsequent wounds on the right leg. Resident A's right leg was amputated below the knee due to infection and to prevent further complications. Employee A reported [they] were surprised Resident A was sent back to the facility and not sent to skilled nursing rehabilitation for care. Resident A is receiving home health care services for treatment and monitoring. When requesting documentation from the facility, Employee A reported the facility has limited access to prior records, but Employee A was able to provide me some limited documentation of Resident A's record for my review.

On 12/6/2023, I interviewed Employee B at the facility whose statement was consistent with Employee A's statement.

On 12/6/2023, I interviewed Resident A at the facility who reported being sent to the hospital due to a fall resulting in a fracture. Resident A reported the physician placed the right leg in an immobilizer and told [them] not to remove the immobilizer. Resident A reported staff tried to take the immobilizer off and [they] refused. Resident A confirmed new wounds with bone exposure developed due to not removing the immobilizer and that they were sent to the hospital. Resident A's right leg was amputated below the knee due to the wounds and subsequent infection. Resident A returned to the facility with home health services in place.

On 12/6/2023, I reviewed Resident A's record which revealed the following:

- Service plan was dated 10/31/2023.
- Resident A makes their own decisions.
- Requires assistance with bathing, dressing, toileting, and personal hygiene.
- Requires assistance with transferring and mobility.
- Home Health services are currently in place to continue to monitor and treat Resident A.
- Care instructions of immobilizer dated 9/17/2023*: Wear it as told by your health care provider. Remove it only as told by your health care provider. Some types of splints can only be removed by your health care provider. Loosen it if your toes tingle, become numb, or turn cold and blue. Keep it clean and dry.*

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:	It was alleged Resident A did not receive appropriate care or monitoring in a timely manner resulting in the development of right leg wounds that resulted in bone exposure and subsequent amputation. Interviews, on-site investigation, and review of limited documentation revealed the following: • Resident A fell resulting in a fracture of the right leg. Exact date of fall could not be determined because documentation could not be provided. • Care instructions for the leg immobilizer are dated 9/17/2023. • On 11/16/2023, a home health nurse removed the immobilizer due to Resident A's complaints of pain. It was then discovered Resident A had wounds on the right lower leg with bone exposure. Resident A was sent to the hospital. • Resident A's right lower leg was amputated due to infection from wounds and bone exposure. Exact date of amputation is unknown due to limited documentation. • Date of Resident A's return from the hospital is unknown, but Resident A returned to the facility with home health services in place. • Resident A admitted to refusing to remove immobilizer to allow staff to clean the right leg, however, there is no documented evidence to support Resident A refused or that staff approached Resident A three times after initial refusal. There is also no evidence to support that facility staff alerted the physician about Resident A's refusals to remove the immobilizer, refused to allow staff to keep the leg clean and dry per the physician care instructions, or that staff monitored Resident A's skin integrity while Resident A's leg was in the immobilizer. The facility did not provide appropriate care, assistance, or safety for Resident A. Therefore, the facility is in violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A does not receive showers in accordance with the service plan.

INVESTIGATION:

On 12/6/2023, Employee A reported Resident A's showers are scheduled for every Tuesday and Friday; and third shift typically completes Resident A's showers. Resident A requires assistance to shower and is currently receiving bed baths. Employee A reported will refuse bathing intermittently. Employee A provided me some limited documentation of Resident A refusing care.

On 12/6/2023, Employee B's statement was consistent with Employee A's statement.

On 12/6/2023, Resident A reported they would like a shower and not a bed bath. Resident reported [they] have not had a shower since October and would prefer those over bed baths but staff will not assist them to shower. Resident A reported staff do not always assist in a timely manner with bathing and sometimes they do not offer it at all on third shift and say [they] refused when [they] did not.

The interview took place in Resident A's room and a strong odor of urine was detected in the room. Upon exiting the interview, Employee A and Employee B were notified by me of the strong odor of urine detected in Resident A's room.

On 12/6/2023, I approached Employee A and Employee B about the odor in Resident A's room and Employee A also confirmed that Resident A is not receiving showers, only bed baths.

On 12/6/2023, I reviewed the limited documentation provided to me by Employee A which revealed the following:

- Resident A is scheduled for bathing on Tuesday(s) and Friday(s) each week.
- On 12/2/2023, Resident A refused to get out of bed.

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 does not receive showers in accordance with the service plan. Interviews, on-site investigation, and review of documentation reveal the following: • Resident A is scheduled for bathing on Tuesday(s) and Friday(s) each week. • Resident A is receiving bed baths currently but would prefer a shower. • It was alleged Resident A refuses bathing, but there is no evidence to support this. • Resident A denied [they] have refused bathing. • A strong odor of urine was detected in Resident A's room during the interview. Due to the strong odor of urine detected in Resident A's room and the lack of documentation demonstrating Resident A refused bathing, the facility is in violation of not providing Resident A appropriate care to include keeping [their] body and clothes clean and [their] environment clean. Violation found.
CONCLUSION:	**VIOLATION ESTABLISHED**

Additional Findings:

INVESTIGATION:

On 12/6/2023, on-site investigation revealed Lou Andriotti, who is listed as the facility administrator, is not the current administrator for the facility. Joy DeVries has been serving as the facility administrator since September 2022.

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 submitted in the application pursuant to which a license, provisional license, or temporary nonrenewable permit has been issued.

ANALYSIS:	Joy DeVries has currently served in the administrator role since September 2022. The facility applicant and/or facility authorized representative did not notify the department of the vacancy or role change within 5 days and has not appointed a new administrator either. Therefore, the facility is in violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 12/6/2023, it was discovered Joy DeVries has been serving as the administrator of the facility since September 2022. The facility has not submitted the appropriate forms to the department to appoint Ms. DeVries as administrator.

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: **(d) Appoint a competent administrator who is responsible for operating the home in accordance with the established policies of the home.**
ANALYSIS:	Joy DeVries has been serving as the facility administrator since September 2022. The facility owner, operator, and governing body has a responsibility to appoint an administrator who is responsible for the operation of the home. As of 12/12/2023, the department has not received the appropriate forms to appoint Ms. DeVries as administrator.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 12/6/2023, it was discovered the record documentation for the Resident A's hospital visit due to fall with injury in September 2023 could not be found or accessed.

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, quality review program.**
	(5) Records must be maintained that demonstrate incident reporting to the team, analyses, outcomes, corrective action taken, and evaluation to ensure that the expected outcome is achieved. These records must be maintained for 2 years.
ANALYSIS:	It was discovered the record documentation for Resident A's hospital visit due to fall with injury in September 2023 could not be found and/or accessed when requested. Incident reporting records are to be completed and must be maintained to ensure analyses, outcomes, corrective actions, and evaluations of the outcome(s) are achieved. These records must also be maintained for a minimum of 2 years. Due to the missing record, the facility is in violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

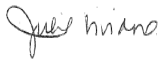
INVESTIGATION:

On 12/6/2023, it was discovered that the recent management change on 11/1/2023 resulted in facility staff no longer having access to prior resident records, so information I requested either could not be provided and/or only very limited information was provided. Of the very limited record information that was provided to me, some of the reports were not dated or signed either.

APPLICABLE RULE	
R 325.1942	**Resident Records**
	(1) A home shall assure that a current resident record is maintained and that all entries are dated and signed.
ANALYSIS:	The facility is to maintain a current resident record and all entries are to be signed and dated. The facility does not have current records for the residents and the limited records the facility does have are incomplete. 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 the same.



12/12/2023

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Julie Viviano Date
Licensing Staff

Approved By:

01/25/2024

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