GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 31, 2024

Joy DeVries-Burns
Vista Springs Riverside Gardens LLC
2610 Horizon Dr. SE Ste 110
Grand Rapids, MI 49546

RE: License #: AH410397993
Investigation #: 2024A1010058
Vista Springs Riverside Gardens

Dear Licensee:

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) 241-1970.

Sincerely,
Lauren Wohlfert

Lauren Wohlfert, Licensing Staff
Bureau of Community and Health Systems
350 Ottawa NW Unit 13 7th Floor
Grand Rapids, MI 49503
(616) 260-7781
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH410397993
Investigation #:	2024A1010058
Complaint Receipt Date:	05/31/2024
Investigation Initiation Date:	06/03/2024
Report Due Date:	07/30/2024
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:	Joy DeVries-Burns
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:	02/09/2024
Expiration Date:	07/31/2024
Capacity:	70
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Staff Person 1 (SP1) is verbally and physically aggressive towards residents.	No
Residents are not bathed and left soiled.	Yes

III. METHODOLOGY

05/31/2024	Special Investigation Intake 2024A1010058
06/03/2024	Special Investigation Initiated - Letter Emailed assigned Kent Co. APS worker Minnie Bracken
06/05/2024	Inspection Completed On-site
06/05/2024	Contact - Document Received Received staff resident rights training document, resident incident report, and resident service plans
06/21/2024	Inspection Completed On-site
06/25/2024	Contact – Document Received Email received from Ms. Bracken
07/15/2024	Contact – Telephone call made Interviewed SP1 by telephone
07/17/2024	Contact – Telephone call made Message left for Witness 1 (W1), telephone call back requested
07/31/2024	Exit Conference

ALLEGATION:

Staff Person 1 (SP1) is verbally and physically aggressive towards residents.

INVESTIGATION:

On 5/31/24, the bureau received the allegations from Adult Protective Services (APS). The complaint read, “[SP1] is abusive to the residents. She was changing a

resident, the resident was screaming, and [SP1] put her hand over the resident's mouth. [SP1] told another resident if she put her hands on her she would be seeing stars. [SP1] pushes the residents hard into chairs when she is sitting them down. She threatens the residents and tells them what she is going to do to them. Several residents in the facility have bruises on them from being handled so roughly. [Resident H] often has bruises and cannot get out of bed or move much."

On 6/3/24, I emailed assigned Kent County APS worker Mareeta Bracken. Ms. Bracken reported she has not interviewed SP1 or Resident H yet. Ms. Bracken stated Resident H was "impaired." Ms. Bracken said she briefly interviewed the facility's administrator Joy DeVries who, "acted as if she was unaware of any conflict amongst staff or unexplained bruises on the clients."

On 6/5/24, I interviewed Ms. DeVries at the facility. Ms. DeVries denied knowledge regarding SP1 putting her hand "over a resident's mouth" or telling a resident "if she put her hands on [SP1] she would be seeing stars." Ms. Devries said no staff or residents reported these incidents to her, therefore she was not previously aware of such incidents occurring. Ms. DeVries explained the only concern she received regarding SP1 was from Relative I1. Ms. DeVries reported Relative I1 previously told her SP1 was "not nice" to Resident I. Ms. DeVries said when she asked Relative I1 and Resident I for additional information, they were unable to provide specific examples of how SP1 was "not nice" to Resident I. Ms. DeVries reported the only information Relative I1 and Resident I provided to her was that SP1 was verbally "not nice" to Resident I, however they did not provide information regarding what SP1 said.

Ms. DeVries reported last week that she heard a verbal altercation between SP1 and another staff person occur in the hallway near the dining room. Ms. DeVries stated when she heard the yelling, she immediately intervened. Ms. DeVries said SP1 is a shift supervisor and certain care staff persons have had a difficult time with SP1 when she held them accountable for not completing their job tasks. Ms. DeVries reported this has caused tension between SP1 and several care staff persons. Ms. DeVries maintained that she has never received any complaints from other care staff persons regarding how SP1 has treated or talked to residents.

Ms. DeVries stated Resident H is currently receiving hospice services and has declined. Ms. DeVries reported Resident H's hospice provider is Emmanuel Hospice and the nurse is in once or twice a week. Ms. DeVries said Resident H fell a couple of weeks ago and did sustain a bruise. Ms. DeVries reported Resident H requires the use of a hoyer lift to transfer.

Ms. DeVries provided me with a copy of Resident H's incident report dated 5/16/24 for my review. The *Detailed Description of accident/incident* section read, "While I was with another resident I was asked for help by [SP2] to help [Resident H] when I walked inside [Resident H] was on the floor. I asked what happened. [SP2] said she found [Resident H] that way when she walked too [sic] her room. We both asked

[Resident H] if she feeling any pain she declined. Shortly after I helped get her back to bed I walked out." There was no documentation regarding any injuries on Resident H after the incident.

Ms. DeVries provided me with a copy of SP1's resident rights training document for my review. The document read, "I acknowledge that I have read, reviewed, understand, and received a copy of Resident Rights, Mistreatment, Mandatory Reporting, Confidentiality Requirements, and Behavioral Interventions under HFA Licensing for Vista Springs Riverside Gardens." I observed the document was signed by SP1 and dated 12/15/22.

On 6/5/24, I interviewed SP3 at the facility. SP3 denied ever seeing SP1 be verbally or physically aggressive towards residents. SP3 reported any staff being verbally or physically aggressive towards a resident in the facility would be out of character for all staff. SP3 said she received resident rights training when she started at the facility. SP3 reported Resident H has declined and is primarily bed bound. SP3 denied knowledge regarding any staff persons intentionally injuring Resident H.

On 6/5/24, I interviewed SP4 at the facility. SP4 reported she observed SP1 "cover [Resident J's] mouth" while Resident J was yelling when they were changing her brief. SP4 said she observed SP1 covered Resident J's mouth "lightly" for approximately five seconds. SP4 stated SP1 said, "[Resident J] stop" when her hand was over her mouth. SP4 said she texted the incident to Ms. DeVries on her cell phone, however she did not know Ms. DeVries got a new telephone number, therefore Ms. DeVries did not receive the text message.

SP4 stated she told SP5 about the incident. SP4 reported she and SP5 told Ms. DeVries about the incident in person the day after it occurred. SP4 explained SP1 and SP5 got into a verbal altercation regarding the incident in the hallway near the dining room.SP4 said SP1 and SP5 "do not get along." SP4 said Ms. DeVries intervened when SP1 and SP5 were loudly arguing in the hallway.

SP4 reported Resident J often paces around the facility and does not engage in meaningful conversation. SP4 reported Resident J does "yell out when she is in plain." SP4 said Resident J cannot make her needs known.

SP4 reported she has never seen SP1, or any other staff persons, hit or injure any residents in the facility. SP4 denied knowledge regarding SP1, or any other staff persons, leaving bruises or intentionally injuring a resident. SP4 said she completed resident rights training when she was hired at the facility.

On 6/5/24, I interviewed SP5 at the facility. SP5's statements were consistent with SP4.

SP5 reported she was present when SP1 told Resident I she “will be seeing stars” if Resident I “put her hands on” SP1. SP5 denied knowledge of SP1 intentionally injuring or leaving bruises on a resident.

On 6/5/24, I attempted to interview Resident H at the facility. I was unable to engage Resident H in meaningful conversation. I observed Resident H sleeping in her bed in her room. I did not observe any injuries on the visible parts of Resident H’s body.

On 6/5/24, I interviewed Resident I at the facility. Resident I denied concerns regarding staff at the facility. Resident I denied being mistreated by care staff. Resident I denied knowing the names of most of the care staff, including SP1.

On 6/5/24, I attempted to interview Resident J at the facility. I was unable to engage Resident J in meaningful conversation. I observed Resident J was well groomed and wore clean clothing. I did not observe any bruises or injuries on the visible parts of Resident J’s body. I observed Resident J pacing around the dining room in the facility.

On 6/21/25, Ms. DeVries reported after she was informed of the allegations, all staff were re-educated and received additional training regarding resident rights and abuse/neglect reporting. Ms. DeVries said she has been actively addressing the issues with staff in fighting inside and outside of the facility. Ms. DeVries stated some staff have been terminated because of poor work performance and attendance issues. Ms. DeVries reported she will continue to engage with staff and address issues related to any internal disputes amongst them.

On 6/25/24, I received an email from Ms. Bracken. Ms. Bracken reported, “[Resident H] passed away on 06/08/2024 due to natural causes.”

On 7/15/24, I interviewed SP1 by telephone. SP1 denied ever putting her hand on Resident J’s mouth to quiet her during the provision of her care. SP1 said she would “never lay her hands” on any resident in the facility. SP1 also denied telling Resident I she would “be seeing stars if she put her hands on her.” SP1 reported she received resident rights training approximately two years ago when she started at the facility.

SP1 reported she is in a supervisor position at the facility and must hold staff accountable and “write them up” if they do not perform their job duties. SP1 stated there have been issues with several care staff persons not completing their job duties and getting written up as a result. SP1 said this has caused conflict between herself and several care staff persons. SP1 reported due to this conflict, staff she supervises are falsely accusing her of mistreating residents. SP1 stated that in addition to staff not completing their job tasks, she has had to “write several of them up” for being late.

On 7/17/24, I attempted to interview Emmanuel Hospice nurse Witness 1 (W1) by telephone. I left a message for W1 and requested a telephone call back.

As of 7/22/24, I have not received a telephone call back from W1.

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents;**
	(2) The policy describing the rights and responsibilities of patients or residents required under subsection (1) shall include, as a minimum, all of the following: **(l) A patient or resident is entitled to be free from mental and physical abuse and from physical and chemical restraints, except those restraints authorized in writing by the attending physician or a physician's assistant to whom the physician has delegated the performance of medical care services for a specified and limited time or as are necessitated by an emergency to protect the patient or resident from injury to self or others, in which case the restraint may only be applied by a qualified professional who shall set forth in writing the circumstances requiring the use of restraints and who shall promptly report the action to the attending physician or physician's assistant. In case of a chemical restraint, a physician shall be consulted within 24 hours after the commencement of the chemical restraint.**
ANALYSIS:	The interview with Ms. DeVries, SP1, SP4, and SP5 revealed there have been inter staff conflicts within the facility. Ms. DeVries reported staff received additional resident rights and reporting abuse and neglect trainings to ensure residents are not mistreated. SP1 denied covering Resident J's mouth or verbally threatening residents in the facility. I was unable to engage Resident J in meaningful conversation and Resident I denied concerns regarding staff or how she is treated by staff. There is insufficient evidence to suggest the facility is not in compliance with this rule.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Residents are not bathed and left soiled.

INVESTIGATION:

On 5/31/24, the complaint read, “The residents are sitting in urine, and it is soaking through the beds and smells like ammonia. The staff are not giving the residents showers on a regular basis.”

On 6/5/24, Ms. DeVries reported residents are bathed twice a week at a minimum and more often as needed or requested. Ms. DeVries denied knowledge regarding any residents not being bathed at least twice a week.

Ms. DeVries said she was made aware of one incident in which Resident K was soiled during third shift into first shift. Ms. DeVries reported Resident K’s family arrived at the facility at approximately 7:00 am the morning of the incident and observed he was soiled. Ms. DeVries stated Resident K’s family members reported the incident to her. Ms. DeVries explained the incident occurred approximately 3 or four months ago and she “looked into it.” Ms. DeVries said she discovered Resident K was changed at approximately 3:00 am that morning and was soiled until approximately 7:00 am when his family arrived at the facility. Ms. DeVries reported Resident K, and all residents’, toileting needs are outlined in their individual service plans. Ms. DeVries denied knowledge regarding any other incidents in which residents were left soiled.

Ms. DeVries reported Resident K has experienced a decline and is currently on hospice services. Ms. DeVries stated Resident K can no longer transfer independently and requires the use of a sit to stand assistive device. Ms. DeVries provided me with a copy of Resident K’s service plan for my review. The *TRANSFERRING* section of the plan read, “Able to get in and out of bed, chair, car, ect., without assistance. Report any changes in ability to transfer to Nurse.” The *MOBILITY* section of the plan read, “Is independent with AMBULATION.” The *TOILETING* section of the plan read, “Independent in toileting activities.” The *BATHING* section of the plan read, “Assistance required – specify: transfers in/out steadying; cueing to wash self; cueing to dry self; shampooing/rinsing/drying hair; applying lotion). Report any changes in ability to bathe to Nurse.”

On 6/5/24, SP3’s statements regarding how often residents bathe were consistent with Ms. DeVries. SP3 denied knowledge regarding any incidents in which residents were not bathed or changed when soiled. SP3 said staff are trained to change a resident immediately when they are found soiled.

On 6/5/24, SP4’s statements regarding resident bathing were consistent with Ms. DeVries and SP3. SP4 reported there have been numerous times when first shift staff arrive and multiple residents are left soiled from third shift.

On 6/5/24, SP5’s statements were consistent with SP4. SP4 reported “third shift staff do not change soiled residents overnight.” SP4 stated as a result, the facility often smells like urine. SP4 said the soiled residents are left for first shift staff to change when they arrive.

On 6/5/24, I attempted to interview Resident K at the facility. I was unable to engage Resident K in meaningful conversation as he was asleep in his bed and did not want to wake up. I observed a halo ring assistive device attached to the frame or Resident K's bed. This device was not outlined in his service plan.

On 6/5/24, I inspected the facility. I did detect the smell of urine in several resident rooms.

On 6/21/25, I re-inspected the facility. During this inspection, I did not detect the smell of urine, or any other foul odors.

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:	Review of Resident K's service plan revealed how often he is to be bathed and the use of a sit to stand assistive device was not outlined. The plan also did not outline the use of a halo ring assistive device that was affixed to his bedframe. There were no instructions for staff to check the device regularly for tightness and to ensure there are no gaps between the device and Resident K's mattress. Resident K's plan also did not provide his hospice providers information. Resident K's plan was not up to date and did not accurately outline his current care needs. The interview with Ms. DeVries, SP4, and SP5 revealed issues with third shift staff not changing soiled residents. On 6/5/24, I detected several resident rooms in the facility smelled like urine. On 6/21/24, I re-inspected the facility and found this issue was addressed as I could no longer detect the smell of urine.
CONCLUSION:	**VIOLATION ESTABLISHED**

I shared the findings of this report with the facility's licensee authorized representative on 7/31/24.

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

07/17/24

Lauren Wohlfert Date
Licensing Staff

Approved By:

07/30/2024

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