GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 28, 2024

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

RE: License #: AH410397993
Investigation #: 2024A1028068
Vista Springs Riverside Gardens

Dear Joy DeVries-Burns:

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 #:	2024A1028068
Complaint Receipt Date:	07/19/2024
Investigation Initiation Date:	07/22/2024
Report Due Date:	09/18/2024
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 do not provide Resident A care in accordance with service plan.	Yes
Additional Findings	Yes

III. METHODOLOGY

07/19/2024	Special Investigation Intake 2024A1028068
07/22/2024	Special Investigation Initiated - Letter
07/22/2024	APS Referral
07/31/2024	Contact - Face to Face Interviewed Admin/Joy DeVries-Burns at the facility.
07/31/2024	Contact - Face to Face Interviewed Employee A at the facility.
07/31/2024	Contact - Face to Face Interviewed Employee B at the facility.
07/31/2024	Contact - Face to Face Interviewed Employee C at the facility.
07/31/2024	Contact - Document Received Received requested documentation from Admin/Joy DeVries-Burns.
08/13/2024	Contact – Telephone Call Made Interviewed complainant by telephone.
08/13/2024	Contact – Telephone Call Made Interviewed hospice staff by telephone.
08/14/2024	Contact – Document Received Received evidence pertaining to allegations.

ALLEGATION:

Staff do not provide Resident A care in accordance with service plan.

INVESTIGATION:

On 7/19/2024, the Bureau received the allegations through the online complaint system.

On 7/22/2024, a referral was made to Homes for the Aged (HFA) through Centralized Intake.

On 7/31/2024, I interviewed facility administrator, Joy DeVries-Burns, at the facility who reported there was a care conference with hospice recently due to Resident A's increasing level of care. Resident A currently requires full assistance with feeding, was recently switched to a puree diet to prevent aspiration when eating and can sometimes refuse meals or may request something different than what is offered at mealtimes. Staff provide Resident A other food options and Resident A's appetite varies. Resident A also drinks nutritional drinks such as Boost or Ensure to ensure nutrition intake is completed due to Resident A's varying appetite and intermittent refusals of meals. Ms. DeVries-Burns reported no knowledge of a bucket of feces being found in Resident A's bathroom and that Resident A uses a bedside commode and does not use the toilet in their bathroom. Ms. DeVries-Burns reported no knowledge of feces being found smeared in the shower or the bathroom. Ms. DeVries-Burns reported Resident A does not use the shower in [their] bathroom but instead utilizes the community spa for bathing. Ms. Devries-Burns reported Resident A's room is cleaned weekly and no staff have reported any issues with feces being found in the shower or bathroom. Ms. DeVries reported no knowledge of soiled clothing being found on the floor in Resident A's room. Resident A has a laundry basket that dirty clothes are placed into and if clothes become soiled with feces or urine they are taken immediately to the laundry for cleaning. Ms. DeVries-Burns provided the requested documentation for my review.

On 7/31/2024, I interviewed Employee A at the facility who reported Resident A requires full assistance with feeding for all meals and is on pureed diet. Employee A also confirmed that Resident A utilizes additional supplement drinks for nutritional purposes as well. Employee A reported if Resident A eats in their room, staff are to provide feeding assistance for the meal, but untouched meals have been found in Resident A's room on several occasions. Resident A cannot feed self and requires assistance with eating and drinking. Employee A reported no knowledge of a bucket of feces being found in Resident A's shower or feces on the shower walls. Resident A uses a bedside commode and the community spa for showers. However, Employee A reported knowledge of soiled clothing to include briefs being found on the floor of Resident A's room a few times.

On 7/31/2024, I interviewed Employee B at the facility whose statement was consistent with Employee A's statement.

On 7/31/2024, I interviewed Employee C at the facility whose statement was consistent with Employee A's statement and Employee B's statement. However, Employee C reported no knowledge of soiled clothing being found in Resident A's room.

On 7/31/2024, I attempted to interview and/or observe Resident A at the facility, but Resident A was unavailable.

On 7/31/2024, I completed an inspection of the facility due to this special investigation.

On 7/31/2024, I reviewed Resident A's service plan which revealed the following:

- Resident A requires assistance with mobility, bathing, dressing, grooming, and toileting.
- Resident A is dependent with meals, eating, and drinking.
- Requires assistance to eat (hand over hand, verbal/non-verbal cuing, encouragement, total feed).
- Resident A is incontinent of bowel and bladder.

I reviewed charting for Resident A for July 2024 which revealed the following:

- On 7/7/2024, 7/8/2024, 7/21/2024, and 7/23/2024, the record is blank for skin assessment. It cannot be determined if the skin assessments were completed or not due to the blank record.
- On 7/7/2024, 7/8/2024, 7/15/2024, 7/21/2024, 7/22/2024, 7/23/2024, 7/27/2024 and 7/28/2024 the record is blank for multiple meals times. It cannot be determined if Resident A was assisted with meals or not or Resident A refused meals.
- On 7/7/2024, 7/8/2024, 7/21/2024, and 7/23/2024, the record is blank for shift rounds. It cannot be determined if staff completed checks on Resident A during rounds due to the blank record.
- On 7/7/2024, 7/8/2024, 7/21/2024, and 7/23/2024, the record is blank for oral care routine. It cannot be determined if staff assisted Resident A with oral or if Resident A refused oral care assistance due to the blank record.
- On 7/7/2024, 7/8/2024, 7/21/2024, and 7/23/2024, the record is blank for personal hygiene. It cannot be determined if staff assisted Resident A with personal hygiene or if Resident A refused personal hygiene assistance due to the blank record.
- On 7/7/2024, 7/8/2024, 7/21/2024, and 7/23/2024, the record is blank for bathroom assistance/toileting. It cannot be determined if staff assisted Resident A with bathroom assistance/toileting or if Resident A refused bathroom assistance/toileting assistance due to the blank record.

On 8/13/2024, I interviewed the complainant by telephone who confirmed Resident A is full assist during mealtimes whether the meals occur in the Resident A's room or the dining room. The complainant reported Resident A does not always receive feeding assistance from staff and that Resident A has gone hungry at times due not receiving assistance. The complainant reported soiled clothing with urine and feces along with a bucket of feces were found in Resident A's room in July 2024. The complainant reported knowledge of this being reported to staff and management to address.

On 8/13/2024, I spoke with hospice staff who confirmed there was a recent care conference with the facility and Resident A's authorized representative to address concerns about feeding. Hospice staff confirmed Resident A is a full assist with feeding, was recently placed on a pureed diet, and that Resident A's appetite is improving. Hospice staff reported no knowledge of soiled clothing being found in Resident A's room.

On 8/14/2024, I received photographic evidence to include metadata of the allegations for my review.

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 that staff do not provide care in accordance with service plan. Interviews, on-site investigation, and review of documentation reveal the following: • Resident A is dependent for all meals to include hand over hand, verbal/non-verbal cuing, encouragement, total feed. • There are multiple days in July 2024 where it cannot be determined if staff provided skin integrity assessments, assistance during mealtimes, assistance with oral care, assistance with personal hygiene, assistance with toileting, or completed checks on Resident A during rounds because the record is blank. • Evidence was found to confirm a bucket of feces was found in Resident A's shower. • Evidence was found to confirm feces was on the shower floor and walls. • Evidence was found to confirm soiled briefs were on the floor of Resident A's room. • No evidence of Resident A refusing of meals or care is documented in the record. Inconsistent staff interviews, blank entries in the care record, and the evidence provided reveal the facility did not provide care in accordance with Resident A's service plan. Therefore, the facility is in violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 7/31/2024, Ms. DeVries-Burns confirmed that staff found Resident A with a bruise on the upper left arm on 7/15/2024 and that Resident A's authorized representative and hospice team were notified of the bruise. Resident A did not know how [they] obtained the bruise and reported there was no pain associated with the bruise. Resident A was monitored afterwards to ensure health.

On 7/31/2024, Employee A reported it cannot be determined how Resident A received the bruise on 7/15/2024. Employee A reported there was no knowledge of Resident A falling on 7/14/2024 or 7/15/2024 and it cannot be determined how Resident A incurred the bruise. Employee A confirmed hospice and Resident A's authorized representative were notified of the bruise but could not confirm the dates they were notified, but that an incident report was completed about the injury.

Employee A reported no knowledge of how the bruise occurred and that Resident A had no pain related to the bruise.

On 7/31/2024, I interviewed Employee C at the facility whose statement was consistent with Employee A's statement and Employee B's statement.

I reviewed Resident A's incident report which revealed the following:

- Date of accident or incident: 7/15/2024 at 7:30 a.m. in Resident A's room.
- Hospice notified at 8:00 a.m. on 7/15/2024.
- Resident A's authorized representative notified on 7/15/2024. (No time notated).
- Description: *[Staff] went to get [Resident A] for the day and noticed right arm with big bruise on it from mid-arm down. Says it doesn't hurt or anything.*
- Body diagram picture notates bruise on left arm, not the right arm as reported.
- Report dated 7/15/2024 and signed at 10:30 am by Ms. DeVries-Burns.

On 8/13/2024, it was reported Resident A's authorized representative was not notified of Resident A's bruise until 7/16/2024 during an evening visit to the facility.

On 8/13/2024, hospice staff reported the hospice team was not notified of the bruise until 7/16/2024 at 18:07.

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, quality review program.**
	(7) The facility must have a policy and procedure to ensure that an incident, once known by facility staff, is reported as soon as possible, but not later than 48 hours after the incident, to a resident's authorized representative or designated health care professional, as appropriate. Verbal or written notification must be documented in the resident's record to reflect the date, time, name of staff who made the notification, and name of the representative or professional who was notified.

ANALYSIS:	Interviews and review of the documentation reveal the following: • A bruise was found on Resident A's arm on 7/15/2024. It cannot be determined which arm Resident A incurred the bruise due to a discrepancy in the staff statement on the report versus the arm that was circled on the body diagram picture on the report. • The report notates hospice was notified at 8:00 a.m. on 7/15/2024 by Ms. DeVries-Burns but hospice staff member reported the hospice team was not notified until 7/16/2024 at 18:07. • The report notates that Resident A's authorized representative was notified on 7/15/2024. (No time notated). • It was reported Resident A's authorized representative was not notified of Resident A's bruise until 7/16/2024 during an evening visit to the facility, but incident report notates the authorized representative was notified by telephone on 7/15/2024. There are discrepancies between the facility incident report, interviews, and provided documentation. It cannot be determined if Resident A's authorized representative or if the hospice team was notified in a timely manner of Resident A's bruise. Therefore, the facility is in violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 7/31/2024, I completed an inspection of Resident A's room and observed heavily stained carpet during the inspection. Ms. DeVries-Burns reported the carpet is supposed to be replaced in the future, but that it gets steamed cleaned regularly.

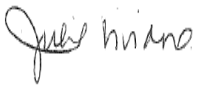
On 8/13/2024, the complainant reported Resident A's carpet has been heavily stained for two years, and while it is steamed cleaned, the stains continue to return.

APPLICABLE RULE	
R 325.1979	**General maintenance and storage.**
	(1) The building, equipment, and furniture shall be kept clean and in good repair.

ANALYSIS:	A resident's room is to be kept clean and in good repair. Resident A's room contains heavily stained carpet, and while the facility steams clean the carpet, the stains continue to return. 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 remains the same.



8/14/2024

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Julie Viviano Date
Licensing Staff

Approved By:

08/27/2024

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