GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 12, 2024

Michael Eby
Vista Springs Ctr/Memory Care & Rediscovery
3736 Vista Springs Ave.
Grand Rapids, MI 49525

RE: License #: AH410400149
Investigation #: 2024A1035073
Vista Springs Ctr/Memory Care & Rediscovery

Dear Mr. Eby:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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,

Jennifer Heim, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(313) 410-3226
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH410400149
Investigation #:	2024A1035073
Complaint Receipt Date:	08/07/2024
Investigation Initiation Date:	08/07/2024
Report Due Date:	10/06/2024
Licensee Name:	Vista Springs Northview, LLC
Licensee Address:	Ste 110 2610 Horizon Dr. SE Grand Rapids, MI 49546
Licensee Telephone #:	(616) 364-4690
Administrator:	Michael Eby
Authorized Representative:	Michael Eby
Name of Facility:	Vista Springs Ctr/Memory Care & Rediscovery
Facility Address:	3736 Vista Springs Ave. Grand Rapids, MI 49525
Facility Telephone #:	(616) 364-4690
Original Issuance Date:	03/04/2020
License Status:	REGULAR
Effective Date:	09/04/2023
Expiration Date:	09/03/2024
Capacity:	56
Program Type:	ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A received poor care. Resident A was transferred to a new room without proper notice.	Yes
Resident A did not receive medications as ordered.	Yes
Additional Findings	No

The complainant identified some concerns that were not related to licensing rules and statues for a home for the aged. Therefore, only specific items pertaining to homes of the aged provisions of care were considered for investigation. The following items were that that could be considered under the scope of licensing.

III. METHODOLOGY

08/07/2024	Special Investigation Intake 2024A1035073
08/07/2024	Special Investigation Initiated - Letter
08/20/2024	Contact - Face to Face
12/5/2024	Inspection Complete. BCAL Sub-Compliance
12/12/2024	Exit Conference: Conducted by phone with Authorized Representative.

ALLEGATION:

Resident A received poor care. Resident A was transferred to a new room without proper notice.

INVESTIGATION:

On August 7, 2024, the department received a complaint through the BCAL online complaint system stating concerns related to Resident A was prescribed protein shakes and medication that had not been given as ordered. Resident A room was moved without consent resulting in a “rapid decline” and decreased quality of care. Resident A thermostat was locked out at 75 degrees resulting in Resident A becoming hypothermic between 5/2/24 and 5/5/24.

On August 20, 2024, an onsite investigation was conducted. While onsite I interviewed Michael Eby Authorized Representative (AR) who states the facility had recently changed ownership and he will assist locating requested documents.

While onsite, I interviewed Staff Person (SP)1 who states she updated service plan to address Resident A becoming hypothermic. SP1 states she spoke with Family A prior to moving Resident A to new room and Family A was agreeable at that time to the move. Resident A and his belongings were moved May 2, 2024, to accommodate his equipment. SP1 was notified of the room temperature not exceeding 75 degrees and notified Michael AR who had SP2 investigate. When SP2 was unable to resolve thermostat issues, Pleune Service Company was contacted and provided service to thermostat on May7, 2024.

While onsite, I interviewed SP3 who states Resident A was “in bed” most of the time towards the end of life. Hypothermic monitoring was ordered every hour, Resident A was able to maintain a proper temperature until the last couple days of life.

On 9/25/2024, a phone interview was conducted with Hospice Nurse A who states Resident A had been declining since his COVID-19 diagnosis although a significant decline was noticed post room change. Hospice Nurse A states “Family A was very upset when she learned of Resident A’s room change stating she was unaware of the change until after it happened.” Hospice Social Worker was notified and requested to provide support to Family A.

On 9/25/2024, a phone interview was conducted with Complainant who states there had been a significant decline in care when the facility was bought out. It was difficult locating staff, and staff were not assisting Resident A with meals. At the beginning of May, Complainant was notified the facility had moved Resident A to a different room to accommodate equipment. Complainant states she was not agreeable to the room change and found out from the Hospice Nurse that Resident A had been moved to a new room. Complainant states a new contract was never presented nor signed related to the room change or increased rates, Resident A’s belongings were left in original room where a new resident had been moved in, and the new room thermostat would not go above 75 degrees. Complainant continued to voice concerns related to Resident A's window being left open at night causing him to become hypothermic, staff not providing protein shakes as ordered, Resident A not receiving medications as ordered, and updated service plan not being signed. Resident A was transferred to new room May 2, 2024, and expired May 30, 2024.

Through record review, the service plan was updated May 16, 2024, to maintain normal body temperature related to Resident A becoming hypothermic on May 5, 2024.

Hospice notes indicate Resident A dressed appropriate and clean during their visits.

Through record review SP1 wrote a note July 29, 2024, stating “Family A was comfortable with room change, Resident A moved from a shared studio room to a friendship suite. Admin continues to monitor and provide support as needed.”

On July 31, 2024, at 09:05 a.m. a “Late Entry” note effective May 2, 2024, was entered by Michael Eby Administrator/ AR stating “Admin spoke to Family A regarding room change. Room move would involve $200 month rent increase. Family A expressed that she was comfortable with room change. Resident A moved from shared studio to a friendship suite. Admin continues to monitor and provide support as needed.”

On July 31, 2024, at 10:44a.m. a “Late Entry” note effective May 5, 2024, was entered stating “resident A moved to new room, spoke with daughter on increase in room size for equipment, negotiated $200 in rate instead of $400 belongings moved to room.” Signed by SP1

On October 1, 2024, Michael AR provided a “Resident Change Form” indicating Resident A room change the and new monthly rent rate including a note indicating Family A provided verbal agreement effective May 2, 2024.

Hospice progress notes entered on May 2, 2024, indicate Hospice Nurse communicated with Family A about Resident A’s room change, Family A stated she was not notified about room change until after the facility staff had moved Resident A. Hospice Social Worker (SW) and Nurse provided comfort and reassurance to Family A related to Resident A being moved without being informed.

Hospice SW progress note indicates she was notified of the facility “moving Resident A without informing family or asking for permission until after it was done. It also appears that the facility was looking to reassess him and might be giving a 30-day notice. Family A is very upset and concerned.” Support was provided to Family A.

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	Rule 21. (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:	Through record review and interview Resident A's room thermometer would not adjust room temperature above 75 degrees. Facility staff were notified of these concerns. SP2 attempted to fix temperature regulator without success. Michael AR had contacted Pleune Service Company to provide service on the heating unit. Resident A was kept in the common area during this time. Resident A was noted by hospice to be hypothermic with a temperature reading between 95.5 to 95.7 degrees Fahrenheit. Facility admission contract states "Vista Springs reserves the right to adjust rates and charges and agrees to notify the Community Member and/ or the authorized representative 30 days prior to changes." Documents and progress notes do not provide evidence proper notification was provided prior to Resident A's room change. "Late Entry" notes entered in July indicate Family A had been notified and agreeable to room changes that occurred in May. Based on information gather admission agreement was not followed therefore this allegation has been substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A did not receive medications as ordered.

INVESTIGATION:

On August 7, 2024, the department received a complaint through the BCAL online complaint system stating concerns that Resident A was prescribed protein shake and medication that had not been given as ordered.

While onsite I interviewed SP1 who states as Resident A declined, he started to pocket food and medications. Hospice nurse was made aware of these changes.

While onsite I interviewed SP3 who states Resident A require assistance with eating and drinking and received medications crushed in applesauce. Resident A would not eat much and there were days he would refuse all medications.

Resident A MAR indicate Protein Shakes were given as ordered with few declines in the month of March. April MAR indicated increased refusal of protein shakes and May MAR indicates Resident refused protein shakes most of the time.

MAR indicates Resident A progressively declined medications as ordered over March, April, and May. Medications circled when refused. At times staff members would indicate refusal reasons on back of MAR but not consistently noting reason for refusal. No progress notes provided to indicate conversations occurred with PCP nor hospice related to the continued refusals of medications.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(1) Medication shall be given, taken, or applied pursuant to labeling instructions or orders by the prescribing licensed health care professional. **medication error occurs when a medication has not been given as prescribed.** **(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 of the following provisions:** **(f) Contact the appropriate licensed health care professional if a resident repeatedly refuses prescribed medication or treatment. The home shall follow and record the instructions given.**

ANALYSIS:	Through interview Resident A declined medications often and required 1:1 supervision and assistance with meals. On multiple accounts, explanatory notes had not been entered related to protein drink and medication refusal. No documentation noted indicating the physician was notified of medication refusals. Through record review facility policy states “if a dose of regularly scheduled medication is withheld, refused, or given at a time other than the scheduled time, the space provided on the front of the MAR for that dosage administration is initialed and circled. An explanatory note is entered on the reverse side of the record provided for PRN documentation. If two consecutive doses of a vital medication are withheld or refused, the physician is notified.” Based on information noted above this allegation has been substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

10/03/2024

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Jennifer Heim, Health Care Surveyor Date
Long-Term-Care State Licensing Section

Approved By:

12/05/2024

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