



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
DIRECTOR

March 11, 2026

Louis Andriotti, Jr.  
IP Vista Springs Timber Ridge Opco, LLC  
PO Box 4338  
East Lansing, MI 48823-9998

RE: License #: AL190383347  
Investigation #: 2026A0622021  
Vista Springs Grand Terrace at Timber Ridge

Dear Mr. 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 that I am not available and you need to speak to someone immediately, please contact the local office at (517) 335-5985.

Sincerely,

A handwritten signature in black ink, appearing to read 'Amanda Blasius', written in a cursive style.

Amanda Blasius, Licensing Consultant  
Bureau of Community and Health Systems  
611 W. Ottawa Street  
P.O. Box 30664  
Lansing, MI 48909

enclosure

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

**I. IDENTIFYING INFORMATION**

|                                       |  |
|---------------------------------------|--|
| <b>License #:</b>                     | AL190383347                                    |
| <b>Investigation #:</b>               | 2026A0622021                                   |
| <b>Complaint Receipt Date:</b>        | 01/27/2026                                     |
| <b>Investigation Initiation Date:</b> | 01/27/2026                                     |
| <b>Report Due Date:</b>               | 03/28/2026                                     |
| <b>Licensee Name:</b>                 | IP Vista Springs Timber Ridge Opco, LLC        |
| <b>Licensee Address:</b>              | 1140 Abbot Rd<br>East Lansing, MI 48823-9998   |
| <b>Licensee Telephone #:</b>          | (303) 929-0896                                 |
| <b>Administrator:</b>                 | Jamie Koerner                                  |
| <b>Licensee Designee:</b>             | Louis Andriotti, Jr.                           |
| <b>Name of Facility:</b>              | Vista Springs Grand Terrace at Timber Ridge    |
| <b>Facility Address:</b>              | 16260 Park Lake Road<br>East Lansing, MI 48823 |
| <b>Facility Telephone #:</b>          | (517) 339-2322                                 |
| <b>Original Issuance Date:</b>        | 11/14/2016                                     |
| <b>License Status:</b>                | REGULAR  |
| <b>Effective Date:</b>                | 05/14/2025                                     |
| <b>Expiration Date:</b>               | 05/13/2027                                     |
| <b>Capacity:</b>                      | 20   |
| <b>Program Type:</b>                  | ALZHEIMERS<br>AGED                             |



**II. ALLEGATION(S)**

|   | <b>Violation Established?</b> |
|---|-------------------------------|
| Medication administration and narcotic medications are not given to residents per label instructions. | No                            |
| Residents medications are being left near resident bedsides.  | Yes                           |
| Direct care workers are sleeping on third shift.  | No                            |
| Staff are expected to work alone, despite residents needing two staff for personal care needs.        | No                            |

**III. METHODOLOGY**

|            |  |
|------------|--|
| 01/27/2026 | Special Investigation Intake<br>2026A0622021   |
| 01/27/2026 | Special Investigation Initiated -phone call to direct care worker, Lauryn Mackey   |
| 01/28/2026 | Inspection Completed On-site   |
| 02/27/2026 | Contact - Telephone call made to direct care workers, Kennedy Redd, Racheal Pardee, Arynn Tiffany, A'reanna Carwright, Brittany Crenshaw and Parker Fyre |
| 03/03/2026 | Email to licensee designee, Lou Andriotti, Jr., regarding documents.   |

**ALLEGATION: Medication administration and narcotic medications are not given to residents per label instructions.**

**INVESTIGATION:**

On 01/27/2025, I received this complaint through the LARA Bureau of Community and Health Systems online complaint system. According to the complaint, medication is not being ordered and staff are not giving medications as directed. The complaint also reported that narcotic medication counts are being altered regularly. The allegation provided no names of residents and no additional contact information to obtain further details.

On 01/28/2026, I completed an unannounced onsite investigation to Vista Springs Grand Terrace at Timber Ridge. During the unannounced onsite investigation, I viewed medications within the medication cart for five residents, Residents A, B, C, D and E. I requested that direct care worker(DCW), Sally Houser pull up residents at random, and I compared all the medications prescribed to each resident according to their medication administration record. Upon review of five residents medication administration record and medications prescribed to each resident, no medication

administration errors were found. All prescribed medications were available within the home. Two residents, Resident C and D had prescribed as needed medications that had not been needed in some time, and were not available within the home. DCW Houser reported that if a resident needed one of these medications, they would call the pharmacy and have it delivered. Upon review of the medication administration records for January 2026 no medication errors were found for the five residents reviewed.

On 01/28/2026, I viewed the narcotic medications that have been prescribed to the five residents reviewed above. The narcotic medications were available. I also viewed a separate document, where staff are counting narcotic medications at the beginning and end of each shift and if the count is off, documentation is made. For January 2026, no concerns were found regarding narcotic medications and the count being altered.

On 01/28/2026, I interviewed DCW Sally Houser in person. She reported that she only works a few times a week but has not noticed any concerns regarding residents' medications not being given as prescribed or the narcotic medication count being altered.

On 02/27/2026, I interviewed DCW Kennedy Redd via phone. She reported that she has not come across any medication errors or residents who have not received medications as prescribed. DCW Redd stated that she has not observed the narcotic medication count to be altered or wrong when working.

On 02/27/2026, I interviewed DCW Arynn Tiffany via phone. She reported that she has not come across any medication errors or residents who have not received medications as prescribed. DCW Arynn stated that she has not observed the narcotic medication count to be altered or wrong when working.

On 02/27/2026, I interviewed DCW A'reanna Carwright via phone. She reported that she has not come across any medication errors or residents who have not received medications as prescribed. DCW Carwright stated that she has observed the narcotic medication count to be off, as some staff are not aware on how to count liquid morphine. She reported that she feels that some staff members just need additional training.

On 02/27/2026, I interviewed DCW Brittany Crenshaw via phone. She reported that she has not come across any medication errors or residents who have not received medications as prescribed. DCW Crenshaw stated that she has not observed the narcotic medication count to be altered or wrong when working.

On 02/27/2026, I interviewed DCW Parker Frye via phone. He reported that he has not come across any medication errors or residents who have not received medications as prescribed. DCW Frye stated that he found the narcotic medication count to be off once and it was about six months ago. DCW Frye was unable to give any specific details regarding the resident or medication.

| <b>APPLICABLE RULE</b> |  |
|------------------------|--|
| <b>R 400.675</b>       | <b>Resident medications.</b>   |
|                        | <b>(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.</b>  |
| <b>ANALYSIS:</b>       | Based upon the unannounced onsite investigation and review of five residents' medication administration records, no evidence was found that resident medications were not given as prescribed. Six direct care workers were also interviewed and reported no concern regarding medication being given to residents properly. Two of the six direct care workers reported concerns about finding the narcotic count to be off at least once but were unable to provide additional information regarding resident names or staff names. Due to the lack of evidence found during the unannounced onsite investigation and during interviews with direct care workers, a violation was not established. |
| <b>CONCLUSION:</b>     | <b>VIOLATION NOT ESTABLISHED</b>   |

**ALLEGATION: Residents' medications are being left near resident bedsides.**

**INVESTIGATION:**

On 01/27/2025, I received this complaint through the LARA Bureau of Community and Health Systems online complaint system. According to the complaint, residents' medications are being left near the bedside.

On 01/28/2026, I completed an unannounced onsite investigation to Vista Springs Grand Terrace at Timber Ridge. During the unannounced onsite investigation, I viewed 16 resident bedrooms. Upon inspection of 16 resident bedrooms, I found one prescribed medication, Hurricane 20% gel unlocked in Resident C's bedroom.

No orders were available for Resident C to administer his own prescribed medication.

On 01/28/2026, I interviewed the administrator at that time, Jamie Koerner in person. She reported that she was unaware that Resident C had the prescribed medication within his bedroom and stated that she would work on getting an order from a doctor or making sure it is locked up properly.

| <b>APPLICABLE RULE</b> |   |
|------------------------|---|
| <b>R 400.675</b>       | <b>Resident medications.</b>  |
|                        | <b>(2) Prescribed medication must be kept in the original pharmacy container and labeled for a specific resident. Over-the-counter medication must be kept in the original manufacturer's container. Prescription and over-the-counter medication must be kept in a locked cabinet or drawer and refrigerated if required. Equipment necessary to administer a medication must be easily accessible and used only for the resident for whom it is prescribed unless generally used for all residents.</b> |
| <b>ANALYSIS:</b>       | Based upon the unannounced onsite investigation, during the inspection of 16 resident bedrooms, I found one prescribed medication unlocked, Hurricane 20% gel in Resident C's bathroom. No order was available for review for Resident C to administer his own medications. Due to the prescribed medication being found on 01/28/2026 unlocked within Resident C's bathroom a violation has been established.  |
| <b>CONCLUSION:</b>     | <b>VIOLATION ESTABLISHED</b>  |

**ALLEGATION:**

- **Direct care workers are sleeping on third shift.**
- **Staff are expected to work alone, despite residents needing two staff for personal care needs.**

**INVESTIGATION:**

On 01/27/2025, I received this complaint through the LARA Bureau of Community and Health Systems online complaint system. According to the complaint, direct care workers are sleeping on third shift. The complaint also alleged that direct care workers are being required to work in the home with only one staff member, despite residents needing two staff for personal care needs.

On 01/28/2026, I completed an unannounced onsite investigation to Vista Springs Grand Terrace at Timber Ridge. During the unannounced onsite investigation, I interviewed administrator, Jamie Koener in person. She reported that if a staff member is caught sleeping on shift they are let go the next day. During the interview, Ms. Koener was unable to provide all the names of direct care workers who were let go for sleeping on shift.

On 03/03/2026, I reached out to licensee designee, Lou Andriotti via email regarding the names of direct care workers who were let go for sleeping on shift. He stated that not all of these workers were caught sleeping at Grand Terrace, as they work in all three licensed buildings on the property. He provided the following names:

Lashandra Wilson, terminated on 11/12/2025  
 De'Asia Whitt, terminated on 12/4/2025  
 Kim Morgan, terminated on 12/4/2025  
 Erika Bergman, terminated on 12/16/2025  
 Raziya Terry, terminated on 1/15/2026

On 02/27/2026, I interviewed six direct care workers via phone. All six direct care workers interviewed stated that they have worked a third shift. All six direct care workers denied seeing any staff sleeping on third shift at Vista Springs Grand Terrace at Timber Ridge.

On 01/28/2026, I completed an unannounced onsite investigation to Vista Springs Grand Terrace at Timber Ridge. During the unannounced onsite investigation, I interviewed administrator, Jamie Koener in person. She reported that they have rearranged their buildings within the last few months and brought all residents who needed two direct care workers for personal care and supervision to another licensed home on the property. Administrator Jamie Koener stated that Vista Springs Grand Terrace at Timber Ridge does not have any residents that require two direct care workers for personal care and supervision. Administrator Jamie Koener stated that the building still always has at least two direct care workers per shift. At the time of the unannounced onsite investigation, the home had 16 residents in care. During my investigation, I viewed three direct care workers on shift during the daytime.

On 02/27/2026, I interviewed six direct care workers via phone. All six direct care workers reported that they had never worked alone within the building. On 02/27/2026, I viewed the staff schedule for the last two months, which also reflected at least two direct care workers on shift 24 hours a day.

| <b>APPLICABLE RULE</b> |  |
|------------------------|--|
| <b>R 400.633</b>       | <b>Staff Requirements</b>  |
|                        | <b>(1) A licensee shall always have sufficient direct care staff on duty for the supervision, personal care, and protection of residents and to provide the services specified in a resident's assessment plan, health care appraisal, and resident care agreement. At a minimum, the ratio of direct care staff to residents must not be less than 1 direct care staff to either of the following:<br/>           (a) 15 residents during waking hours or 20 residents during sleeping hours for large group homes and congregate facilities.</b> |

|                    |  |
|--------------------|--|
| <b>ANALYSIS:</b>   | Based upon the interviews with the administrator and six direct care workers, there was not enough evidence to determine if the home was out of ratio or did not have enough direct care workers to meet resident needs. No evidence was found that direct care workers were working alone during their shifts and based upon the resident register on 1/28/26, only two direct care workers are needed during the waking hours. No direct care workers reported staff to be sleeping during third shift at the home and the licensee designee has addressed any previous concerns by terminating staff who were found sleeping. Administrator Jamie Koener reported that all shifts provide at least two direct care workers. Based upon the staff schedules viewed, resident register and interviews completed no evidence was found that only one staff member has been working within the building, nor that staff are sleeping on third shift, therefore a violation was not established. |
| <b>CONCLUSION:</b> | <b>VIOLATION NOT ESTABLISHED</b>   |

**IV. RECOMMENDATION**

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



03/11/2026

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Amanda Blasius  
Licensing Consultant

Date

Approved By:



03/11/2026

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Dawn N. Timm  
Area Manager

Date