



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 13, 2026

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

RE: License #: AL190383349
Investigation #: 2026A0622020
Vista Springs Lakeside Gardens 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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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 cursive script, appearing to read "Amanda Blasius".

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

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

I. IDENTIFYING INFORMATION

License #:	AL190383349
Investigation #:	2026A0622020
Complaint Receipt Date:	01/27/2026
Investigation Initiation Date:	01/27/2026
Report Due Date:	03/28/2026
Licensee Name:	IP Vista Springs Timber Ridge Opco, LLC
Licensee Address:	1140 Abbot Rd East Lansing, MI 48823-9998
Licensee Telephone #:	(303) 929-0896
Administrator:	Jamie Koerner
Licensee Designee:	Louis Andriotti, Jr.
Name of Facility:	Vista Springs Lakeside Gardens at Timber Ridge
Facility Address:	16260 Park Lake Road East Lansing, MI 48823
Facility Telephone #:	(517) 339-2322
Original Issuance Date:	11/14/2016
License Status:	REGULAR
Effective Date:	06/21/2024
Expiration Date:	06/20/2026
Capacity:	20
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Staff are expected to work alone, despite residents needing two staff for personal care needs.	No
Direct care workers are sleeping on third shift	No
Medication administration and narcotic medications are not given to residents per label instructions.	No
Resident medications are being left near the bedside.	No
Additional findings	Yes

III. METHODOLOGY

01/27/2026	Special Investigation Intake 2026A0622020
01/27/2026	Special Investigation Initiated - Letter
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.
03/11/2026	Inspection Completed-BCAL Sub. Compliance
03/13/2026	Exit conference with licensee designee, Louis Andriotti, Jr.

ALLEGATIONS:

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

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 Lakeside Gardens 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 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 01/28/2026, I completed an unannounced onsite investigation to Vista Springs Lakeside Gardens 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 Vista Springs Lakeside Gardens at Timber Ridge. Administrator Jamie Koener stated that Vista Springs Lakeside Gardens at Timber Ridge does have 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 15 residents in care. During my investigation, I viewed three direct care workers on shift during the daytime. During the unannounced onsite inspection, I confirmed that five residents require a two person assist with personal care and transfers.

On 02/27/2026, I interviewed direct care worker, Kennedy Redd via phone. She reported that she has never worked alone within the home. She stated that she does work on third shifts and observed staff nap during their breaks.

On 02/27/2026, I interviewed direct care worker, Racheal Pardee via phone. She reported that she has never worked alone within the home. She stated that she does work on third shifts and has seen staff sleeping during shifts once or twice. She stated that she tries to make sure all residents are taken care of.

On 02/27/2026, I interviewed direct care worker, Arynn Tiffany via phone. She reported that she has never worked alone within the home. She stated that she has seen staff sleep on third shift. She stated that De'Asia Whitt, would sleep the whole shift on the couch and she has seen other staff members sleeping too. DCW Tiffany stated that she reported her concerns to management, as she felt there were not enough staff to care for the residents within the home.

On 02/27/2026, I interviewed direct care worker, A'reanna Carwright via phone. She reported that she has never worked alone within the home. She stated that she has seen staff sleeping on third shift and two of them were terminated.

On 02/27/2026, I interviewed direct care worker, Brittany Crenshaw via phone. She reported that she has never worked alone within the home. She stated that she has not seen anyone sleeping onsite and denied sleeping on third shift.

On 02/27/2026, I interviewed direct care worker, Parker Frye via phone. He reported that he has never worked alone within the home. He stated that she has seen staff sleep on third shift and has also seen some other staff sleep during their breaks. DCW Frye was unable to provide any names.

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.

APPLICABLE RULE	
R 400.633	Staffing requirements.
	(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: (a) 15 residents during waking hours or 20 residents during sleeping hours for large group homes and congregate facilities. (b) 12 residents for small group and family homes.

ANALYSIS:	Based upon 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. Based upon documentation reviewed the home has 15 residents as of 01/28/2026 and has three direct care workers during waking hours and at least two direct care workers during sleeping hours. Direct care workers interviewed reported staff to be sleeping during shift but also reported that many were terminated due to sleeping. The licensee designee took proactive action and terminated five direct care workers for sleeping during third shift. A violation was not established as Vista Springs Lakeside Gardens at Timber Ridge is within staff ratio as they had 15 residents on 01/28/2026 and were staffing at a minimum two direct care workers due to resident needing two staff for personal care and transfers.
CONCLUSION:	VIOLATION NOT ESTABLISHED

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 Lakeside Gardens 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. 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 Aryn Tiffany via phone. She reported that she has not come across any medication errors or residents who have not received medications as prescribed. DCW Aryn 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.

APPLICABLE RULE	
R 400.675	Resident medications.
	(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.

ANALYSIS:	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.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Resident medications are being left near the bedside.

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 Lakeside Gardens at Timber Ridge. During the unannounced onsite investigation, I inspected all 15 residents bedrooms for unlocked prescribed and over the counter medications. During the inspection, no unlocked or over the counter medications were found in the 15 resident bedrooms.

APPLICABLE RULE	
R 400.675	Resident medications.
	(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.

ANALYSIS:	During the unannounced onsite investigation, all 15 resident bedrooms were inspected for unlocked prescribed and over the counter medications. No evidence was found of prescribed and over the counter medications being left unlocked within the resident bedrooms, therefore a violation was not established.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDING:

INVESTIGATION:

On 01/28/2026, during the unannounced onsite investigation, I inspected all 15 resident rooms. During the inspections, I found a can of Lysol on Resident D's bathroom counter. The Lysol can was accessible to Resident D.

APPLICABLE RULE	
R 400.645	Environmental Health
	(7) Poisons, caustics, and other dangerous materials must be stored and safeguarded in nonresident, non-food preparation areas, and storage areas.
ANALYSIS:	At the time of the unannounced onsite investigation, all 15 resident bedrooms were inspected. During the inspections, a can of Lysol was found on a resident's bathroom counter. Due to the can of Lysol being stored on a resident's bathroom counter, a violation was established.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

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




03/13/2026

Amanda Blasius
Licensing Consultant

Date

Approved By:



03/13/2026

Dawn N. Timm
Area Manager

Date