



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 14, 2026

Louis Andriotti, Jr.
Vista Springs Imperial Park at Timber Ridge
16260 Park Lake Road
East Lansing, MI 48823

RE: License #: AH190401909
Investigation #: 2026A1041004
Vista Springs Imperial Park at Timber Ridge

Dear Licensee:

Attached is the Special Investigation Report for the above-mentioned facility. Due to the violation 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) 335-5985.

Sincerely,

A handwritten signature in cursive script that reads "Tammie Daniels".

Tammie Daniels, Licensing Staff
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

License #:	AH190401909
Investigation #:	2026A1041004
Complaint Receipt Date:	04/06/2026
Investigation Initiation Date:	04/06/2026
Report Due Date:	06/06/2026
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:	Rebecca Olson
Authorized Representative	Louis Andriotti, Jr., Designee
Name of Facility:	Vista Springs Imperial Park at Timber Ridge
Facility Address:	16260 Park Lake Road East Lansing, MI 48823
Facility Telephone #:	(517) 339-2322
Original Issuance Date:	11/04/2020
License Status:	REGULAR
Effective Date:	08/01/2025
Expiration Date:	07/31/2026
Capacity:	40
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
The facility failed to follow Resident A’s service plan.	Yes
The facility was short staffed.	No
Facility staff were not trained in using the sit-to-stand prior to resident care.	No
Additional Findings	No

III. METHODOLOGY

04/06/2026	Special Investigation Intake 2026A1041004
04/06/2026	Special Investigation Initiated - Letter Email sent to Complainant
04/06/2026	Contact - Telephone call made Phone interview with complainant
04/13/2026	Contact - Face to Face Onsite interview with Administrator and Employees 1, 2, and 3
04/21/2026	Contact - Telephone call made Interview with Employee 4
04/22/2026	Contact - Telephone call made Interview with Employee 5
04/29/2026	Contact - Document Received Received requested documents from Authorized Representative
04/30/2026	Contact - Document Received Received requested information from Authorized Representative
05/14/2026	Exit Conference

The complainant identified some concerns that were not related to home for the aged licensing rules and statutes. Therefore, only specific items pertaining to homes

for the aged provisions of care were considered for investigation. The following items were those that could be considered under the scope of licensing.

ALLEGATION:

The facility failed to follow Resident A's service plan.

INVESTIGATION:

On 04/06/2026 I interviewed the complainant by telephone. The complainant alleged that the facility failed to follow Resident A's service plan. The complainant alleged that Resident A's service plan included the use of a sit-to-stand device and two staff members for all transfers. The complainant alleged that on multiple occasions, only one staff member transferred Resident A while using the device.

On 04/06/2026, I reviewed information provided by the complainant including Resident A's documentation of care furnished by the facility between September 2025 and December 2025. The documentation revealed that Employees 4, 5, 6, 7, 8, and 9 were all specifically listed in Resident A's documentation as being one of the staff that transferred Resident A alone using the sit-to-stand. Specific days which were documented included:

- September 30, 2025
- October 1, 2, 4, 5, 6, 7, 9, 14, 15, 16, 25, 27, and 31, 2025
- November 3, 4, 6, 10, 13, and 22, 2025
- December 7 and 24, 2025

On 04/13/2026, I interviewed the Administrator, Rebecca Olson. The Administrator reported that when Resident A moved into the facility in 2024, she required the use of a sit-to-stand device and the assistance of two staff members for transfers. The Administrator reported Resident A's service needs for transfers remained the same for the whole time she lived at the facility. The Administrator reported that Resident A moved out in 2025.

On 04/13/2026, I reviewed Resident A's most recent service plan dated 02/2025 which revealed the following:

"Transferring-Assistance Directions: Provide assistance with all transfers. Uses two assist with sit to stand..."

On 04/13/2026, I reviewed staff work schedules from September 2025 through December 2025. The review revealed that staff members documented by Resident A to have worked on specific days and failed to have two people present for a transfer mentioned above matched the staff who were on the staff schedule for those days.

On 04/21/2026, attempt was made to contact all staff members which were named in Resident A's care documentation. I interviewed Employee 4 and Employee 5 by telephone, and both denied being aware of any time in which Resident A was transferred with only one staff member using the sit-to-stand device. There was no answer or return call from Employee 6, Employee 7 or Employee 8 during the investigation.

On 04/22/2026, I interviewed Employee 9 by telephone. Employee 9 reported being aware of multiple times when Resident A was transferred with only one staff member using the sit-to-stand device.

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 documentation received by Resident A revealed several instances when only one staff member used the sit-to-stand device during a transfer. Review of the staff schedules between September 2025 and December 2025 revealed that Resident A's account of who was on duty matched the facility staff schedule. Interview revealed that Employee 9 was aware of multiple instances where only one staff member transferred Resident A with the sit-to-stand device. Due to this corroborating evidence, it was determined the facility did not ensure staff were compliant with Resident A's service plan.
CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION:

The facility was short staffed.

INVESTIGATION:

The complainant alleged that on multiple occasions, only one staff member assisted Resident A with transfers due to repeated staff shortages.

The Administrator reported that between September 2025 and December 2025, the facility had two shifts which included day shift hours of 6:45 a.m. to 7 p.m., and night shift hours of 6:45 p.m. to 7 a.m. The Administrator reported that between those months in 2025, the resident census varied between 22 and 32. The Administrator

reported that after a long process of review, the facility's operational program made a transition and beginning in January 2026, the new program operation went in effect. The Administrator reported that part of the operational transition included reviewing the needs of any potential resident to determine level of acuity, and any individual with higher acuity, including need for two-person assistance, would be referred to another more appropriate setting. The Administrator reported there were currently no residents residing in the facility who require two staff members to assist with care and no residents with behavioral concerns.

On 04/13/2026, I reviewed the facility staff schedule for specific dates in September, October, November, and December 2025 in which Resident A documented at least one transfer with only one staff member while using the sit-to-stand device. The schedule revealed that for all days included, the staff coverage hours equaled at least two caregivers and one medication technician for each shift. The schedule revealed many days had one to two hours overlapping where there would be more than three staff members on duty during a shift.

On 04/29/2026, I reviewed information provided by the facility AR, Louis Andriotti, regarding how many residents residing at the facility between September 2025 and December 2025 needed the assistance of two staff members for at least one service. The review revealed that there were six residents in September 2025; four residents in October 2025; two residents in November 2025; and one resident in December 2025.

During interviews with Employee 1, Employee 2, and Employee 3 while at the facility, all three denied knowledge of staffing deficits during the time when Resident A resided at the facility. All three employees reported that there were no current residents residing at the facility who needed two staff for care services.

Employee 4 reported there were times when Resident A or other residents requiring two-person assistance would have to wait longer for a second person to help. Employee 4 reported this was due to not having enough staff for the amount of work there was. Employee 4 acknowledged there were no current residents residing at the facility who needed assistance of two staff members.

Employee 5 reported that although residents were cared for, there were times when more staff would have helped due to the number of residents needing two people at one time.

On 04/23/2026, I reviewed the facility's day and night shift staffing schedules for 04/05/2026 through 04/11/2026. The schedules revealed no staffing concerns for the resident acuity currently reported.

APPLICABLE RULE	
R 325.1931	Employees; general provisions.

	<p>(5) The home shall have adequate and sufficient staff on duty at all times who are awake, fully dressed, and capable of providing for resident needs consistent with the resident service plans.</p>
<p>ANALYSIS:</p>	<p>Review of staffing hours worked between September 2025, and December 2025 revealed that total staff hours included at least three staff members on day shift and three staff members on night shift with some days having staffing overlap of one to two hours. Interviews with Employee 4 and Employee 5 confirm that at times, they felt that more staff were needed due to resident acuity levels. Based on the resident census and resident acuity reported during the months reviewed in 2025, the potential existed for lack of adequate staff to provide for the needs of all residents however, since January 2026, the home program structure transitioned, and it has been determined that residents with higher acuity would be referred to a more appropriate setting.</p> <p>The facility no longer has residents who need the assistance of two staff members for any services being provided. Due to the home program being changed, the potential staffing issue related to the need for two staff members for care services has been addressed and there is a lack of evidence that the same issue would occur in the future. Review of current staffing hours revealed no concerns. As a result, the violation cannot be established.</p>
<p>CONCLUSION:</p>	<p>VIOLATION NOT ESTABLISHED</p>

ALLEGATION:

Facility staff were not trained in using the sit-to-stand prior to resident care.

INVESTIGATION:

The complainant alleged that some staff were not trained prior to using the sit-to-stand device.

The Administrator reported that all staff were trained to use the sit-to-stand device prior to using it with residents. The Administrator reported that a signed acknowledgment of this training is kept in individual employee files after completion.

I reviewed Employee 9's training record. The record revealed Employee 9 completed the sit-to-stand device training and signed an acknowledgment of the training.

During interviews with Employee 1, 2, 3, 4, 5, and 9, all reported that they had been trained in using a sit-to-stand device prior to providing resident care with it.

APPLICABLE RULE	
R 325.1931	Employees; general provisions.
	(6) The home shall establish and implement a staff training program based on the home's program statement, the residents service plans, and the needs of employees, such as any of the following: (c) Personal care.
ANALYSIS:	Based on employee interviews and the training record review, there is a lack of evidence to determine that staff were not trained in using the sit-to-stand device prior to using it with residents.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the status of the license.

Tammie Daniels

04/30/2026

Tammie Daniels
Licensing Staff

Date

Approved By:

Andrea L. Moore

05/14/2026

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

Date