



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 14, 2026

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

RE: License #: AL190383349
Investigation #: 2026A0622059
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.

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 dark ink, appearing to read 'Amanda Blasius', with a stylized, cursive script.

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

License #:	AL190383349
Investigation #:	2026A0622059
Complaint Receipt Date:	08/20/2026
Investigation Initiation Date:	08/20/2026
Report Due Date:	09/19/2026
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:	Beci Olson
Licensee Designee:	Louis Andriotti, Jr., Designee
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:	03/16/2026
Expiration Date:	09/15/2026
Capacity:	20
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
On 8/14/26, Resident A returned from the ER with antibiotics for a UTI but had not received them as of 8/19/2026.	Yes
Resident B experienced prolonged painful urination and distress before finally being sent to the ED on 8/19 despite the facility nurse's objections.	No
Additional Findings	Yes

III. METHODOLOGY

08/20/2026	Special Investigation Intake 2026A0622059
08/20/2026	Special Investigation Initiated – Email contact and additional information received from complainant.
08/24/2026	Contact- Voicemails left for direct care workers, Cassandra Gerard and Morgan Zea. Phone call to direct care workers, Mari Lopez and Sophia Castillo.
08/26/2026	Inspection Completed On-site
08/31/2026	Contact - Telephone call made. Email sent to licensee designee, Louis Andriotti requesting documentation.
09/01/2026	Contact- Phone call made to Guardian A1, PACE nurse, Autum Wright and direct care worker Shayla Smith
09/02/2026	Inspection Completed On-site and phone call to Progressive Care Medical Group
09/08/2026	Exit conference with licensee designee, Louis Andriotti, Jr
09/14/2026	APS referral

ALLEGATION: On 8/14/26, Resident A returned from the ER with antibiotics for a urinary tract infection but had not received them as of 8/19/2026.

INVESTIGATION:

On 08/20/2026, I received this complaint through the LARA Bureau of Community

and Health Systems online complaint system. According to the complaint, on 8/13/2026, Resident A was sent to the hospital for a urinary tract infection and was sent back to the facility on the same day with a prescription for antibiotics but had not received them as of 8/19/2026.

On 08/20/2026, I had email contact with Complainant and received direct care workers contact information and additional documentation pertaining to the complaint.

On 08/24/2026, I left voicemails for direct care workers, Cassandra Gerard and Morgan Zea. As of 9/9/2026, no response has been received.

On 08/26/2026, I completed an unannounced onsite investigation to Vista Springs Lakeside Gardens at Timber Ridge. During the unannounced onsite investigation, I interviewed direct care workers and reviewed documentation.

On 08/26/2026, I interviewed direct care worker(DCW), Kairi Archie in person. He stated that he heard about Resident A not receiving his medication. He stated that he observed Resident A to have brown colored urine in her brief on 8/19/26 so he informed the medication technician, Shayla Smith. DCW Archie stated that he was off the week of August 10th-15th.

On 08/26/2026, I interviewed direct care worker, Jamie Jenkins in person, who identified as the nurse for the facility. She stated that the reason for the delay in obtaining Resident A's prescribed medication was because Resident A returned to the facility without discharge paperwork. DCW Jenkins stated that Resident A works with PACE and PACE delivers all her medications. She stated that they did not receive any orders for Resident A, therefore they were unable to provide her with prescribed medication for a few days. I requested that DCW Jenkins review her notes and provide me with any contacts regarding Resident A's return from the hospital, prescribed medication and also obtain her discharge paperwork.

On 08/26/2026, Resident A's discharge paperwork was unavailable for review. I viewed Resident A's *Medication Administration Record* for the month of August. According to Resident A's *Medication Administration Record* she was prescribed Nitrofurantoin Mono/mac 100mg CAP, take one capsule by mouth twice daily for five days. Resident A was administered this medication starting on 8/20/26 at 5pm and received her last dose on 8/25/2026 at 5pm.

On 08/26/2026, I confirmed through Resident A's paperwork, that she is not a participant through PACE.

On 08/26/2026, I reviewed Resident A's *Observation* notes. I was informed by direct care worker, Jamie Jenkins that observation notes are to be documented for out of the ordinary observations for each resident. Only two observation notes were available for review after Resident A was discharged from the hospital. On 8/18/26,

direct care worker, Morgan Zea documented, “[Resident A] is having blood in urine.” On 8/22/2026, direct care worker, Morgan Zea documented, “[Resident A’s] urine is bloodier than it typically has been.” No additional documentation was available to be reviewed regarding staff contacting Resident A’s doctor, hospital or pharmacy regarding Resident A’s prescription for a urinary tract infection.

On 08/31/2026, an email was sent to licensee designee, Louis Andriotti requesting documentation that was unavailable during the onsite investigation. On 09/01/2026, I received the documentation requested.

I reviewed Resident A’s *Emergency Department Provider Note*. According to the documentation, Resident A’s doctors’ office, Progressive Care Medical Group requested her discharge documentation from Sparrow Hospital Medical Records on 8/17/2026. Progressive Care Medical Group provided the documentation to Vista Springs Lakeside Gardens at Timber Ridge on 8/17/2026 via fax at 5:15pm. Resident A’s *Emergency Department Provider Note*, dated 8/13/26 stated the following:

“Chief complaint: Hematuria (Pt to ED via EMS from Visita Springs with reports of Hematuria since Monday, worse today- pain. Alert to norm with history of Alzheimer’s.”

“ED patient care summary: Labs remarkable for slight AKI with creatinine of 1.18 from .87. Labs otherwise unremarkable for acute abnormality Hemoglobin stable 12.1. No leukocytosis concerning for systemic infection. UA remarkable for UTI with 3+ blood, positive nitrates, 3+leukocyte esterase, greater than 100 WBC. Patient given dose of Macrobid in the emergency department. Givens patients positive UA, sent home with five-day course of Macrobid.”

The *Emergency Department Provider Note* was signed off by the doctor on 8/14/2026 at 12:40pm.

On 09/01/2026, I asked DCW Jamie Jenkins via email for documentation of her contacting the doctor’s office to obtain Resident A’s discharge documentation. DCW Jenkins stated that she did not have any written documentation and stated that she called the doctor’s office on 8/14/2026 and requested that they obtain the discharge documentation for Resident A.

On 09/02/2026, I contacted Progressive Care Medical Group regarding Resident A and contacts they have documented regarding staff from Vista Springs Lakeside Gardens at Timber Ridge calling on behalf of Resident A. I was informed that the only documentation for staff calling on behalf of Resident A during the time frame of 8/10/26-8/20/26, is staff requesting emergency discharge documentation for Resident A on 8/17/2026. According to Progressive Care Medical Group, the request was made on 8/17/26 and they were also able to obtain the documentation from the hospital on 8/17/26, which was provided the same day to Vista Springs Lakeside Gardens at Timber Ridge.

On 09/02/2026, I completed an onsite inspection to Vista Springs Lakeside Gardens at Timber Ridge. During the onsite inspection, I asked DCW Jamie Jenkins, DCW Jessica Hunter and licensee designee, Louis Andriotti for documentation or reasoning to explain why Resident A's medication was not obtained until 8/20/2026. I was given the explanation that the discharge paperwork was not received until 8/17/26 after hours and then the prescription was sent to the wrong pharmacy, therefore they had to ask Hometown pharmacy to obtain the prescription from the other pharmacy. It was reported that Emily Homeezyn who is a lead concierge contacted the pharmacy on 8/19/2026 regarding the prescription being transferred over to the correct pharmacy. DCW Jamie Jenkins, DCW Jessica Hunter, lead concierge Emily Homeezyn and licensee designee, Louis Andriotti were unable to provide a reason as to why no contacts to the pharmacy were made on 8/18/2026.

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 interviews conducted and documentation available for review it was found that Resident A returned to Vista Springs Lakeside Gardens at Timber Ridge on 8/14/26 from the emergency room. According to the <i>Emergency Department Provider Note</i> , Resident A was diagnosed with a urinary tract infection and was given one dose of Macrobid in the emergency room and was sent home with a five-day course of Macrobid. DCW Jamie Jenkins reports that she called Resident A's doctor's office on 8/14/26 to obtain the discharge documentation, but no documentation was available to confirm this phone call, along with the doctor's office confirming that they did not receive a phone call from staff requesting this documentation until 8/17/26. According to the fax documentation, Vista Springs Lakeside Gardens at Timber Ridge received the documentation on 8/17/26 at 5:15pm. No effort was made to contact the pharmacy until 8/19/2026 to obtain a prescription for Resident A regarding her urinary tract infection. Consequently, Resident A did not receive her prescribed Nitrofurantoin Mono/mac 100mg CAP until 8/20/2026 at 5pm, which was five days after she was discharged from the emergency room with this prescription order and sent back to the adult foster facility.
CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION: Resident B experienced prolonged painful urination and distress before finally being sent to the ED on 8/19 despite the facility nurse's objections.

INVESTIGATION:

On 08/20/2026, I received this complaint through the LARA Bureau of Community and Health Systems online complaint system. According to the complaint, Resident B has been acting out, and it was requested she be checked for a UTI in early July 2026, but nothing was done. The complaint stated she was sent on 8/19 to the emergency room despite the facility nurse stating, "she was fine". According to the complaint, Resident B has had painful urination, distress and screaming out, but the facility nurse said she didn't need to be sent. The complaint stated that the overnight medication technician sent her via ambulance against facility nurse wishes.

On 08/20/2026, I had email contact with Complainant and received direct care workers contact information and additional documentation pertaining to the complaint.

On 08/24/2026, I left voicemails for direct care workers, Cassandra Gerard and Morgan Zea. As of 9/9/2026, no response has been received.

On 08/24/2026, I interviewed direct care worker, Sophia Castillo via phone. She stated that on August 18th she reported to the home nurse, Jamie Jenkins that Resident B was screaming in pain while urinating. DCW Castillo stated that the nurse checked Resident B, but Resident B reported she was not in pain. DCW Castillo explained that nurse Jamie Jenkins didn't seem too concerned and left the room. DCW Castillo reported that she observed Resident B screaming when moving her arms and legs, along with appearing confused and no longer having an appetite. DCW Castillo stated that she reported her concerns to the next direct care worker, Cassandra Gerard.

On 08/24/2026, I interviewed direct care worker, Mari Lopez via phone. She stated that she observed Resident B to be in pain and the home nurse did not attend to her. DCW Lopez stated that she observed Resident B pointing at her back, was tired and was screaming very loudly. DCW Lopez explained that she was not present when the home nurse checked her. DCW Lopez stated that they attempted to call Resident B's guardian before sending her out to the emergency room. DCW Lopez stated that Resident B returned from the hospital and is now on end of life care through PACE.

On 08/26/2026, I completed an unannounced onsite investigation to Vista Springs Lakeside Gardens at Timber Ridge. During the unannounced onsite investigation, I interviewed direct care workers and reviewed documentation.

On 08/26/2026, I interviewed direct care worker(DCW), Kairi Archie in person. He stated that he heard Resident B yell in pain and noted that she was declining. He stated he was not working when she was sent out.

On 08/26/2026, I interviewed direct care worker, Laura Winston in person. She reported that she had no information on Resident B screaming or being in pain. She stated that she understands that now Resident B is bed bound, can only take small bites of food and is in an end of life transition. DCW Winston stated that it's her understanding that Resident B is now on hospice and prescribed morphine for pain.

On 08/26/2026, I interviewed direct care worker, Jamie Jenkins in person. She identified as the facility nurse. She stated that she was not aware of Resident B being in pain prior to being sent out to the hospital and she denied any staff member coming to her with this concern. DCW Jenkins stated that Resident B receives PACE services and they visit her every other week at the home. DCW Jenkins stated that Resident B has been switched to end of life care recently. I requested that DCW Jenkins review her notes and provide me with any contacts regarding Resident B's and also obtain her hospital discharge paperwork.

On 08/26/2026, Resident B's discharge paperwork was unavailable for review. I viewed Resident B's *Medication Administration Record* for the month of August. According to Resident B's *Medication Administration Record* she was prescribed Cephalexin 500mg capsule, take one capsule by mouth twice daily for five days on 8/20/2026. On 8/21/2026, Resident B was prescribed the following medications on an as needed basis:

- Glycopyrrolate 1mg, Haloperidol Lactate 2mg, Morphine Sulfate 100mg, ondansetron ODT 8mg tablet and Lorazepam 2mg.

On 08/26/2026, I viewed observation notes for Resident B from the time frame of 8/01/2026-8/26/26. Only one observation note was documented before 8/19/2026 and stated that on 8/18/2026 at 3:15am, it was documented that "[Resident B] seems to be having pain, but the staff were unsure of the location of pain. [Resident B] is not communicating the location at this time. [Resident B] was given a PRN of Tylenol."

On 08/31/2026, an email was sent to licensee designee, Louis Andriotti requesting documentation that was unavailable during the onsite investigation. On 09/01/2026, I received the documentation requested.

On 09/01/2026, I reviewed Resident B's *After Visit Summary*, dated 8/19/2026. According to the summary, Resident B was seen at the hospital on 8/19/26 for back pain and her diagnosis was a urinary tract infection.

On 09/01/2026, I interviewed PACE nurse, Autumn Wright via phone. Ms. Wright checked their computer system and confirmed that no phone calls were received

from staff regarding Resident B being in pain in early August. According to their documentation system, Resident B was seen by a PACE nurse on 8/3/26 and 8/11/26 and there were no notes regarding pain or urinary tract infection. Ms. Wright confirmed that Resident B was seen on 8/21/2026 and was switched to end of life care due to a decline in her health. Ms. Wright also reported that they were notified that Resident B was diagnosed with a urinary tract infection on 8/19/26 and was given antibiotics.

On 09/02/2026, during an onsite inspection, I interviewed direct care worker, Maria Lightner in person. She reported that she does not feel that Resident B was denied medical care or any medical care was delayed. DCW Lightner explained that Resident B continues to scream as of today, 9/2/26. DCW Lightner stated that her urinary tract infection has been treated and she is also provided additional pain medication, therefore she feels the screaming is behavior related. DCW Lightner stated that when she asks Resident B why she is screaming, she just states she is tired.

On 09/02/2026, during an onsite inspection, I interviewed direct care worker, Jaquetta Speed in person. She reported she also heard Resident B screaming but she does not feel that Resident B was denied any medical treatment or should have been seen sooner by medical professionals. DCW Speed also confirmed that Resident B continues to scream despite receiving all medications, including pain medications. DCW Speed stated it was her understanding that it's a behavior that can occur at the end of life.

APPLICABLE RULE	
R 400.689	Resident health care.
	(3) In case of an accident or sudden adverse change in a resident's health condition, a facility shall obtain needed health care immediately.

ANALYSIS:	Based upon the documentation reviewed and interviews conducted, it was found that Resident B was seen in the emergency room within an appropriate time frame for her symptoms displayed. According to interviews with Ms. Wright from PACE, a nurse saw Resident B on 8/03/26 and 8/11/26 and no concerns were found. Based on observation notes, concerns were noted on 8/18/26 regarding Resident B screaming and appearing to be in pain. Additionally, the <i>After Visit Summary</i> documented that Resident B was seen on 8/19/26 with a complaint of back pain. A violation was not established as there was not enough documentation or evidence through interviews to confirm that there was delay in medical care for Resident B.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDING:

INVESTIGATION:

On 08/26/2026, I completed an unannounced onsite investigation, to Vista Springs Lakeside Gardens at Timber Ridge. During the unannounced onsite investigation, I reviewed documentation for Resident A. Observation notes were obtained for Resident A. According to the observation note documented on 08/13/2026 at 11:30am "On 8/11/26, direct care worker, Maria Lightner informed the health and wellness director about [Resident A] having blood in brief. Staff made numerous attempts to obtain a urine sample and was [sic] still unsuccessful. No new orders at this time, current plan of care is still ongoing. Will follow up with health and wellness director."

On 8/13/26 at 4:30pm, the following observation note was documented: "[Resident A] has been urinating blood since Tuesday morning. [Resident A's] primary physician and nurse on staff agreed that she should be sent out for further evaluation. Her son was notified by health and wellness director."

On 09/01/2026, I had email contact with the health and wellness director/direct care worker, Jamie Jenkins to determine the reason for the delay in sending Resident A for evaluation regarding her urinary tract infection. DCW Jenkins stated the following: "we had an order to obtain a urine, we were unable to get a urine sample, her [Guardian A1] was contacted and did not agree with her being sent to the ER due to us being unable to obtain a urine sample, and the little bit of urine that was obtained did have blood in it, I personally spoke with Dr. Eisenberg and he agreed she needed to be sent out for further evaluation."

On 09/01/2026, I interviewed Guardian A1 via phone. He confirmed that he received a call from the home regarding Resident A. He stated that he asked if the home could obtain urine sample from within, but he reported that he never told the home

that she should not be sent out to the hospital, nor did he deny her receiving medical care.

On 09/01/2026, I interviewed direct care worker Shayla Smith via phone. She reported that staff were told to attempt to get a urine sample for Resident A, but it was difficult due to Resident A wearing adult incontinence briefs. DCW Smith reported that direct care staff attempted to get a urine sample for several days, but it was her understanding that staff could not obtain enough urine for the required testing.

On 09/02/2026, I interviewed direct care worker, Maria Lightner in person. She reported that she discussed her concerns regarding Resident A with DCW Jamie Jenkins. She stated that she was instructed to attempt to obtain a urine sample from Resident A for two days and then on the third day she brought up her concerns again. DCW Lightner stated that Resident A was having blood in her urine, there was an odor and she appeared in pain when urinating. DCW Lightner stated that she felt Resident A should have been sent out for medical treatment sooner.

Resident A's *Emergency Department Provider Note*, dated 8/13/26 stated the following:

“Chief complaint: Hematuria (Pt to ED via EMS from Visita Springs with reports of Hematuria since Monday, worse today- pain. Alert to norm with history of Alzheimer's.”

“ED patient care summary: Labs remarkable for slight AKI with creatinine of 1.18 from .87. Labs otherwise unremarkable for acute abnormality Hemoglobin stable 12.1. No leukocytosis concerning for systemic infection. UA remarkable for UTI with 3+ blood, positive nitrates, 3+leukocyte esterase, greater than 100 WBC. Patient given dose of Macrobid in the emergency department. Givens patients positive UA, sent home with five-day course of Macrobid.”

APPLICABLE RULE	
R 400.689	Resident health care.
	(3) In case of an accident or sudden adverse change in a resident's health condition, a facility shall obtain needed health care immediately.

ANALYSIS:	Based upon documentation reviewed and interviews conducted a violation was established as it was determined that Resident A started showing symptoms of a urinary tract infection on Monday, August 10 th and was not sent to the hospital until the afternoon of August 13 th . Although direct care workers were attempting to obtain a urine sample from Resident A, they were unsuccessful for over 48 hours, while Resident A's change in health remained consistent with blood in her urine.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

Physical plant violations leading to the provisional license that was issued on 3/16/2026 have successfully been corrected. At this time a corrective action plan has been requested regarding the current violations identified in this report.



09/09/2026

Amanda Blasius
Licensing Consultant

Date

Approved By:



09/14/2026

Dawn N. Timm
Area Manager

Date