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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 20, 2022

Louis Andriotti, Jr.
Vista Springs Wyoming LLC
Ste 110
2610 Horizon Dr. SE
Grand Rapids, MI 49546

RE: License #: AH410397992
Investigation #: 2022A1028074
Vista Springs Wyoming

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 I am not available, and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

Julie Viviano, Licensing Staff
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
Cell (616) 204-4300

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

I. IDENTIFYING INFORMATION

License #:	AH410397992
Investigation #:	2022A1028074
Complaint Receipt Date:	08/10/2022
Investigation Initiation Date:	08/11/2022
Report Due Date:	10/09/2022
Licensee Name:	Vista Springs Wyoming LLC
Licensee Address:	Ste 110, 2610 Horizon Dr. SE Grand Rapids, MI 49546
Licensee Telephone #:	(616) 259-8659
Administrator:	Louis Andriotti, Jr.
Authorized Representative:	Mackenzie Ferguson
Name of Facility:	Vista Springs Wyoming
Facility Address:	2708 Meyer Ave SW Wyoming, MI 49519
Facility Telephone #:	(616) 288-0400
Original Issuance Date:	12/10/2019
License Status:	REGULAR
Effective Date:	06/10/2022
Expiration Date:	06/09/2023
Capacity:	147
Program Type:	AGED

	ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Staff did not provide care in accordance with Resident A's service plan.	No
Staff did not respond to Resident A's call light in a timely manner.	Yes
Resident A did not receive medications in a timely manner.	Yes
Additional Findings	Yes

III. METHODOLOGY

08/10/2022	Special Investigation Intake 2022A1028074
08/11/2022	Special Investigation Initiated - Letter
08/11/2022	APS Referral APS referral made to Centralized Intake.
08/29/2022	Contact - Face to Face Interviewed Admin/Sarah Woltman at the facility.
08/29/2022	Contact - Face to Face Interviewed Employee A at the facility.
08/29/2022	Contact - Face to Face Interviewed Employee B at the facility.
08/29/2022	Contact - Document Received Received Resident A's service plan, record notes with physician orders, and MAR from Admin/Sarah Woltman.
10/20/2022	Exited with Sarah Woltman via telephone. Report sent to AR/Louis Andriotti, Jr. and Admin/Sarah Woltman.

ALLEGATION:

Staff did not provide care in accordance with Resident A's service plan.

INVESTIGATION:

On 8/8/2022, the Bureau received the allegations from the online complaint system.

On 8/8/2022, I emailed an Adult Protective Services (APS) referral to Centralized Intake.

On 8/29/2022, I interviewed the facility administrator, Sarah Woltman, at the facility, who reported Resident A was on hospice services and required assistance with all care due to being an increased fall risk. Ms. Woltman reported staff followed Resident A's service plan along with hospice recommendations and physician orders. Resident A incurred a fall on 4/30/2022 resulting in a laceration to the left arm. The left arm required stitches and the facility followed the physician discharge instructions for Resident A. Ms. Woltman also reported no knowledge of any staff member "popping wheelies or using a wheelchair in appropriately for [Resident A] or any other resident. That would not be tolerated and would be grounds for immediate termination". Ms. Woltman also reported a staff member was caught using Resident A's personal items and it was addressed immediately with that staff member being terminated. Ms. Woltman provided me a copy of Resident A's service plan and physician discharge orders for my review.

On 8/29/2022, I interviewed Employee A at the facility who reported Resident A was an increased fall risk and was not able to use the call light appropriately at times. Resident A required assistance with all care and mobility. Employee A reported staff followed Resident A's service plan while Resident A was at the facility and staff also followed the physician discharge orders after Resident A incurred a fall resulting in stitches. Employee A reported resident service plans are reviewed daily to ensure appropriate care. Employee A reported no knowledge of any staff member using a wheelchair inappropriately with any residents. However, Employee A reported knowledge of a recent staff member using Resident A's personal belongings and that staff member was terminated immediately because "that behavior is not tolerated here".

On 8/29/2022, I interviewed Employee B at the facility who reported Resident A was receiving hospice services and required assistance with all care. Resident A was an increased fall risk and incurred an injury in April 2022 resulting in a laceration that required stitches. Employee B reported staff followed the physician discharge orders pertaining to wound care and that staff followed Resident A's service plan. Employee B reported resident service plans are reviewed daily to ensure appropriate care and to address any changes. Employee B reported no knowledge of any staff using a wheelchair unsafely with any residents but reported knowledge

that a recent staff member was terminated due to using Resident A's personal belongings. Employee B reported that behavior is not tolerated at the facility.

On 9/9/2022, I reviewed Resident A's service plan which revealed the following:

- Resident A could not make needs known.
- Resident A required assistance with all care.
- Resident A was a two person assist with all mobility and transfers.
- Resident A required frequent checks by staff throughout all shifts for care and safety.
- Service plans were reviewed by supervisors and medication techs daily for appropriate care and instruction.

I reviewed Resident A's facility incident reports relating to falls which revealed Resident A incurred a fall on 4/30/2022 resulting in a laceration that required stitches. A second fall occurred on 7/18/2022 due to Resident A placing [their] lift recliner into a standing position. Hospice and the physician were contacted for both falls and made recommendations to the facility.

I also reviewed Resident A's physician discharge orders from the 4/30/2022 fall that resulted in the left arm laceration, which revealed Resident A would have a have a *follow up with PCP to have sutures removed in 10-12 days. Keep cut dry for the first 24-48 hours, After first 24 to 48 hours wash around the cut with clean water 2 times a day. Cover the cut with a thin layer of petroleum jelly.*

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:	It was alleged care staff were not following Resident A's service plan. Interviews and review of documentation reveal there is no evidence to support this allegation and that staff followed physician discharge orders and Resident A's service plan. It was also alleged a staff member was using the wheelchair inappropriately with Resident A. There is no evidence to support this allegation. It was confirmed a former staff member used Resident A's personal belongings. However, the facility took immediate and appropriate action to address the issue and terminated the staff member immediately. No violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Staff did not respond to Resident A's call light in a timely manner.

INVESTIGATION:

On 8/29/2022, Ms. Woltman reported call light response times are not to exceed 15 minutes, but there have been occasions when the response time has exceeded 15 minutes. Staff who violated the call light policy were counseled individually. There are all staff in-service meetings that occur monthly with staff being reminded and re-educated on the policy as well. Ms. Woltman reported Resident A did not always use the call lights, so Resident A was placed on frequent staff checks to ensure appropriate care and safety. Ms. Woltman provided me a copy of Resident A's call light log for my review.

On 8/29/2022, Employee A reported call light response times are not to exceed 15 minutes, but there have been times when the response time has taken longer than 15 minutes due to assisting other residents. Employee A reported sometimes staff will forget to reset the call light, so it can appear the call light response is longer than it was. Employee A confirmed staff are reminded at monthly in-service meetings to continue to adhere to the call light response time of 15 minutes or less.

On 8/29/2022, Employee B reported all staff typically respond to call light in 15 minutes or less but there have been times when the call light has exceeded the 15 minutes. Employee B reported staff sometimes also forget to turn the call light off once they respond or to reset the call light so it can appear that the call light response took longer. Employee B reported staff are reminded at in-service meetings to continue to abide by the 15-minute call light response time.

On 9/9/2022, I reviewed Resident A's call light response log which revealed 60 call light response times that exceeded more than 15 minutes. Six of the call response times were more than one hour.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(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.
ANALYSIS:	Interviews and review of documentation reveal 60 documented call light response times that exceeded the 15-minute facility policy. Six of the documented call light response times exceeded more than one hour. Staff did not appropriately respond to Resident A's call light in accordance with the facility policy and therefore is in violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A did not receive medications in a timely manner.

INVESTIGATION:

On 8/29/2022, Ms. Woltman reported there was a medication error on 7/29/2022 and it was reported immediately to management by staff. It was also reported to hospice, the physician, and Resident A's authorized representative. Resident A was given .25 ml of the prescribed .50ml morphine dose. Ms. Woltman reported Resident A was provided the correct the dosage immediately following the error and the medication tech was also immediately provided re-education and counseling on rights of medication administration and the correct dosage. Ms. Woltman reported medication techs are trained at orientation and receive continuous education throughout the year to ensure competency. Ms. Woltman reported this was "human error" that was immediately recognized and reported with the facility providing re-education to the staff member involved. Ms. Woltman provided me Resident A's medication administration record (MAR) for July 2022 for my review.

On 8/29/2022, Employee A reported all medication techs receive education and training at orientation and then continuing education throughout the year. Employee A reported medication errors do occur but are not common. If a medication error

occurs, the medication tech is to report it immediately to management and it is then reported to the physician, the licensing department, and the resident's authorized representative. Employee A reported the medication tech will then receive re-education and counseling due to the med error or may even be removed from the medication cart until competency is demonstrated again. Employee A reported knowledge of Resident A's medication error and that the staff member involved received counseling and re-education.

On 8/29/2022, Employee B reported knowledge of Resident A's medication error and that the staff member involved received immediate counseling and re-education. Employee B reported medication errors occur, but they are not often and depending on the severity, medication techs can be removed from medication administration duties. Employee B reported when a medication error occurs, it must be reported immediately to management, the physician, the licensing department, and the resident's authorized representative.

On 9/9/2022, I reviewed Resident A's MAR which revealed Resident A was to receive Morphine 100mg/5ml solution .25ml by mouth every three hours as needed for pain and shortness of breath beginning 6/29/2022 to 7/26/22. On 7/26/22, Resident A's Morphine 100mg/5ml solution was increased to .50ml by mouth every three hours as needed for pain. The reported medication error occurred on 7/29/2022. Further review of the MAR revealed the medication error was not documented as a medication error; it was instead documented as Resident A receiving .50ml.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(2) The giving, taking, or applying of prescription medications shall be supervised by the home in accordance with the resident's service plan.
ANALYSIS:	On 7/29/2022, Resident A was not administered the correct amount of Morphine in accordance with physician orders. Resident A was administered .25 ml instead of .50 ml of Morphine. Also, while the medication error was immediately addressed by the facility upon its discovery, review of Resident A's MAR does not show evidence the medication error was documented correctly in the record. Therefore, the facility is in violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

On 8/29/2022, Ms. Woltman reported she will be assuming the role of the facility administrator on 9/5/2022 and the change of administrator forms would be sent to the department prior to Ms. Woltman becoming administrator.

As of 9/12/2022, the facility has not received the change of administrator forms for Ms. Woltman.

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following: **(d) Appoint an administrator who is responsible for operating the in accordance with established policies of the home.**
ANALYSIS:	The facility's governing bodies did not submit the Change of Administrator forms and supporting documentation to appoint Sarah Woltman as the facility's current administrator.
CONCLUSION:	**VIOLATION ESTABLISHED.**

IV. RECOMMENDATION

Contingent upon an approved corrective action plan, I recommend the status of this license remains unchanged.

Julie Viviano

9/12/2022

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Julie Viviano Date
Licensing Staff

Approved By:

Andrea L. Moore

10/06/2022

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