GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 15, 2022

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

RE: License #: AH410397992
Investigation #: 2023A1028011
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 #:	2023A1028011
Complaint Receipt Date:	12/01/2022
Investigation Initiation Date:	12/05/2022
Report Due Date:	01/31/2023
Licensee Name:	Vista Springs Wyoming LLC
Licensee Address:	Ste 110 2610 Horizon Dr. SE Grand Rapids, MI 49546
Licensee Telephone #:	(616) 259-8659
Administrator:	Sarah Woltman
Authorized Representative:	Louis Andriotti, Jr.
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?
Resident A eloped from the facility on 11/11/2022.	Yes
Additional Findings	No

III. METHODOLOGY

12/01/2022	Special Investigation Intake 2023A1028011
12/05/2022	Special Investigation Initiated - Letter APS referred complaint to HFA department. APS denied complaint investigation.
12/05/2022	APS Referral APS referred complaint to HFA department. APS denied complaint investigation.
12/13/2022	Contact - Face to Face Interviewed staff/Employee A at the facility.
12/13/2022	Contact - Face to Face Interviewed staff/Employee B at the facility.
12/13/2022	Contact - Face to Face Interviewed staff/Employee C at the facility.
12/13/2022	Contact - Face to Face Interviewed staff/Employee D at the facility.
12/13/2022	Contact - Face to Face Interviewed staff/Employee E at the facility.
12/13/2022	Contact - Document Received Received Resident A's service plan and care history from Employee A.
12/14/2022	Contact - Telephone call made Interviewed Admin/Sarah Woltman by telephone and received Resident A’s care history and facility sign in/sign out instructions via email.

ALLEGATION:

Resident A eloped from the facility on 11/11/2022.

INVESTIGATION:

On 12/5/2022, the Bureau received the allegations from the online complaint system.

On 12/13/2022, I interviewed Employee A at the facility who reported Resident A resided in assisted living and was allowed to leave the facility by signing in and out at the front desk. Employee A reported had a DPOA in place for financial obligations, but Resident A was their own person. Employee A reported Resident A left the facility after 9:00pm after family left for the evening on 11/11/2022. Resident A exited through the side door of the facility and did not sign out. Resident A was brought back to the facility before 10:00pm by police after a neighbor near the facility found Resident A in [their] back yard. Employee A reported Resident A was sent to the hospital for further evaluation and upon return was moved to memory care.

On 12/13/2022, I interviewed Employee B at the facility who reported Resident A has a DPOA in place but was allowed to sign [their selves] in and out of the facility due to residing in assisted living. Employee B reported Resident A had family visiting until about 9:00pm on 11/11/2022 and Resident A was last seen by staff around 9:00pm. Resident A then exited through the side door of the facility after family left and did not alert staff and did not sign out. Resident A was brought back to the facility shortly before 10:00pm by police due to being found in a neighbor's backyard wedged between the fence and a tree. It was recommended Resident A be sent to the hospital for further evaluation, but family declined. The facility updated Resident A's service plan and moved Resident A to memory care, which is a secure unit. Employee B reported Resident A did not exhibit any wandering or exit seeking behaviors prior to the elopement and always signed in and out. Employee B reported Resident A would only leave the facility with family, and never alone. Also, both Resident A and the family were consistent about signing in and out of the facility. Employee B reported residents in assisted living are allowed to sign in and out of [their] own accord and there is a front desk person who monitors entrances and exits of the facility. Employee B provided me a copy of Resident A's care history for 11/1/1/2022 and Resident A's prior and most recent service plans.

On 12/13/2022, I interviewed Employee C at the facility who reported Resident A eloped from the facility on 11/11/2022 through the side exit of building after family left for the evening. Resident A was brought back to the facility by police around 10:00pm after being found in a nearby backyard. To their knowledge, Employee C reported Resident A has always signed in and out of the facility and only left with family when exiting the facility. Employee C reported Resident A did not demonstrate

exit seeking behaviors prior to the elopement and “since [Resident A] was in assisted living then, [they] were allowed to come and go. [They] were supposed to sign in and out”. Employee C reported there is a front desk person who monitors entrances and exits of the facility and that facility staff “complete rounding on all residents every two hours”. Employee C reported the rounding checks are documented by staff each shift and to their knowledge, Resident A was last seen at 9:00pm by staff on the evening of the elopement.

On 12/13/2022, I interviewed Employee D and Employee E at the facility. Employee D’s statements and Employee E’s statements are consistent with Employee A’s statements, Employee B’s statements, and Employee C’s statements.

On 12/13/2022, I completed an inspection of the facility due to this investigation. Resident A was observed in the memory unit being assisted by staff. However, during my entire inspection, there was no one present at the front desk monitoring who was entering or exiting the facility.

On 12/14/2022, I interviewed the facility administrator, Sarah Woltman, by telephone. Ms. Woltman confirmed Resident A was last seen by staff around 9:00pm after visiting family left for the evening. Resident A then exited the facility on 11/11/2022 and did not sign out or alert staff [they] were leaving. Resident A was found in a neighbor’s yard by police and returned to the facility. Ms. Woltman reported Resident A was gone from the facility for less than hour. Staff recommended Resident A be sent to the hospital for further evaluation, but family declined. Ms. Woltman reported Resident A did not exhibit prior exiting seeking behaviors and that Resident A and family were consistent with signing in and out of the facility. Prior to the elopement, Resident A only left the facility with family and did not go out on [their] on. Due to Resident A’s elopement, Resident A’s service plan was updated, and Resident A was moved to the memory care unit which is more secure. Ms. Woltman also reported the front desk person monitors the entrances and exits of the facility and who is signing in and out. Ms. Woltman provided me a Resident A’s care history and facility sign in/sign out instructions via email.

On 12/15/2022, I reviewed Resident A’s updated service plan that is dated 12/13/2022 which revealed the following:

- Resident A requires supervision with dressing, grooming, and hygiene.
- Resident A requires assistance with bathing.
- Resident A is independent with toileting, eating, oral care, mobility with use of walker and transferring.
- Resident A is provided supervision and redirection to avoid and prevent elopement.
- Resident A receives frequent rounding checks while in the community and throughout each shift.

I also reviewed Resident A’s prior service plan dated 5/19/2022 which revealed the following:

- Resident A required supervision for grooming, and personal hygiene.
- Resident A required assistance with bathing and dressing.
- Resident A was independent with eating, oral care, toileting, mobility with use of walker and transferring.
- Resident A received frequent rounding checks while in the community and throughout each shift.

I also reviewed Resident A's care history for 11/11/2022 which revealed the following:

- Staff provided rounding checks at 10:44am and 10:46pm.
- Staff completed a Covid-19 temperature check at 8:47am and 5:59pm.
- Staff provided Resident A supervision with grooming, personal hygiene, and dressing from 10:46pm to 10:47pm.

I also reviewed the facility incident report for 11/11/2022 which revealed:

- At 10:01p MP received a call from MTP that it was reported by local neighbor to local PD the sound of someone in the back bush area on southwest side of Vista property. Local PD responded and discovered an elderly woman outside.
- All responsible parties notified.
- [Resident A] was checked onsite by Paramedics, FD with no injury.
- PD recommended member be checked by ER for further testing. Family refused. Hospice notified.

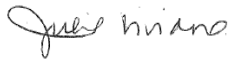
I reviewed the front desk administration job description which revealed residents are to be monitored during business hours for check-in and check-out.

APPLICABLE RULE	
R 325.121	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following: **(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.**

ANALYSIS:	Resident A resided in assisted living and on 11/11/2022, Resident A eloped through the side door of the facility without alerting staff and without signing out. Resident A was found in a neighboring back yard and brought back to facility around 10:00pm. Interviews, on-site inspection, and review of documentation reveal Resident A did not exhibit prior exit seeking behaviors; and Resident A and family were consistent about signing in and out of the facility. It was reported staff last saw Resident A in [their] room on 11/11/2022 around 9:00pm, just after visiting family had left for the evening. However, review of Resident A's care history for 11/11/2022 does not support this. Resident A's care history for 11/11/2022 reveals: • Staff provided rounding checks at 10:44am and 10:46pm. • Staff completed a Covid-19 temperature check at 8:47am and 5:59pm. • Staff provided Resident A supervision with grooming, personal hygiene, and dressing from 10:46pm to 10:47pm. There is no documented evidence that staff saw Resident A in [their] room at 9:00pm on 11/11/2022 as reported in interviews and just prior to the elopement. Staff did also not document the frequent rounding checks as required by the service plan until after the elopement once Resident A was brought back to the facility at 10:00pm. Violation found.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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



12/15/2022

Julie Viviano Date
Licensing Staff

Approved By:

01/27/2023

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