GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

February 6, 2023

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

RE: License #: AH410397992
Investigation #: 2023A1021027
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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- The signature of the authorized representative 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 that I am not available and you need to speak to someone immediately, please contact the local office at (517) 284-9730.

Sincerely,

Kimberly Horst, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH410397992
Investigation #:	2023A1021027
Complaint Receipt Date:	01/23/2023
Investigation Initiation Date:	01/24/2023
Report Due Date:	03/22/2023
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?
Staff members bring children to work.	No
Residents are treated disrespectfully.	No
Additional Findings	Yes

III. METHODOLOGY

01/23/2023	Special Investigation Intake 2023A1021027
01/24/2023	Special Investigation Initiated - On Site
01/24/2023	APS Referral Referral sent to centralized intake
01/27/2023	Contact-Telephone call made Interviewed health and wellness director Heather Calvin
02/06/2023	Exit Conference Exit conference with authorized representative Louis Andriotti, Jr

The complainant placed allegations against the facility handling of Covid-19. This complaint was investigated under special investigation 2023A1021025. 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:

Staff members bring children to work.

INVESTIGATION:

On 01/23/2023, the licensing department received a complaint with allegations employees bring their children to work.

On 01/24/2023, the allegations in this report were sent to centralized intake at Adult Protective Services (APS).

On 01/24/2023, I interviewed administrator Sarah Woltman at the facility. Ms. Woltman reported staff person 1 (SP1) did bring her minor child to the facility due to daycare and vehicle issues. Ms. Woltman reported she was at the facility around 8:00pm and observed a minor child sitting in the common area. Ms. Woltman reported SP1 reported she did not want to call in for her shift but did not have childcare for her child. Ms. Woltman reported SP1 received facility counseling regarding bringing children to work. Ms. Woltman reported she is working on the schedule to get SP1 transferred to a different shift so that childcare is not an issue. Ms. Woltman reported SP1 is a good employee. Ms. Woltman reported this was an isolated incident and has never happened before.

I reviewed facility Counseling Form dated 1/19/23. The form read,

> *"Employee was witnessed bringing child to work and was not in appropriate work attire. Employee was instructed that she can not bring child to work. Formal written warning and if this should happen again it would result in termination. Employee will work towards proper daycare."*

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: **(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.**
For Reference: R 325.1901	**Definitions.**
	(16) "Protection" means the continual responsibility of the home to take reasonable action to ensure the health, safety, and well-being of a resident as indicated in the resident's service plan, including protection from physical harm, humiliation, intimidation, and social, moral, financial, and personal exploitation while on the premises, while under the supervision of the home or an agent or employee of the home, or when the resident's service plan states that the resident needs continuous supervision.

ANALYSIS:	Interview and document revealed SP1 did bring her minor child to work. While this event did occur, it was an isolated incident and is not a systemic issue throughout the facility.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Residents are treated disrespectfully.

INVESTIGATION:

The complainant alleged residents have bruises from incorrect transfers. The complainant alleged that residents have bedsores. The complainant alleged SP2 pushes, shoves, and pulls the residents.

On 01/24/2023, I interviewed SP3 at the facility. SP3 reported she has never seen a resident transferred incorrectly. SP3 reported residents receive good care at the facility. SP3 reported there is only one resident that has a bedsore. SP3 reported the resident is bedbound and is near end of life. SP3 reported the facility is working with home care to manage the wound. SP3 reported no concerns with caregivers at the facility.

On 01/24/2023, I interviewed SP4 at the facility. SP4 reported she has not observed bruises or bedsores on residents. SP4 reported residents are transferred appropriately. SP4 reported she has no concerns with resident and staff interactions.

On 01/24/2023, I interviewed SP5 at the facility. SP5 reported there are two residents with bedsores. SP5 reported hospice is involved with their care and the facility is appropriately managing the bedsores. SP5 reported no concerns with staff and resident interactions.

On 01/24/2023, I interviewed SP6 at the facility. SP6 reported residents receive good care at the facility. SP6 reported she has not observed any bruises on the residents. SP6 reported she has no concerns with staff and resident interactions.

On 01/24/2023, I interviewed The Care Team health worker Jim Dusenberry at the facility. Mr. Dusenberry reported the facility is well ran with excellent caregivers. Mr. Dusenberry reported residents are treated respectfully and are transferred correctly. Mr. Dusenberry reported no concerns with staff and resident interactions at the facility.

On 01/24/2023, I interviewed Resident A at the facility. Resident A reported she feels safe at the facility and would recommend the facility. Resident A reported the

facility does have staff turnover, but staff members treat her respectfully. Resident A reported no concerns with the facility.

On 01/24/2023, I interviewed Resident B at the facility. Resident B reported she requires staff to transfer her, and she has never been transferred incorrectly. Resident B reported staff members treat her well and she has no concerns with living at the facility.

Ms. Woltman reported there was an incident with SP2 and a memory care resident. Ms. Woltman reported the resident went to kick SP2 and SP2 put her hands up to protect herself. Ms. Woltman reported SP2 received verbal counseling with instruction to take another staff member in the room and if the resident is violent to leave the room. Ms. Woltman reported she has no concerns with SP2 behaviors. Ms. Woltman reported there are three residents that have a bedsore and hospice or homecare is working with the facility to manage the bedsore. Ms. Woltman reported she has not observed concerning bruises on residents. Ms. Woltman reported she has not received any complaints from residents or family members on resident and staff interactions.

While at the facility I observed multiple resident and staff interactions. I observed staff members having meaningful conversations with residents, assisting residents to the meal service, and providing direct resident care.

On 01/27/2023, I interviewed health and wellness director Heather Calvin by telephone. Ms. Calvin reported it was reported that SP2 hit a community member. Ms. Calvin reported they interviewed the reporting source and SP2. Ms. Calvin reported it was determined that the community member went to kick SP2 and SP2 put her hands up to block the kick. Ms. Calvin reported the resident is in memory care and unable to provide an account of what happened. Ms. Calvin reported the community member can be combative and has a history of hitting staff members and other residents. Ms. Calvin reported no concerns with SP2.

I reviewed staff training for SP2. The training revealed SP2 was trained in abuse and neglect and dementia training.

I reviewed facility counseling form for SP2. The form read,

> *“It was reported that employee was witnessed hitting a community member. Upon investigation it was found that (community member) had kicked employee and employee threw her hands up to block (community member) kick. It was not an intentional hitting of (community member). Investigation performed by mp. Employee will continue to go into member room with additional caregiver present or also reapproach member at a later time.”*

I reviewed service plans for the three residents that have bedsores. Each service plan had wound care instructions for staff members. In addition, each service plan

had instructions for staff members to follow to encourage pressure relief off the wound.

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:	Interviews conducted, observations made, and document review revealed residents are treated with respect and dignity. There is lack of evidence to support this allegation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

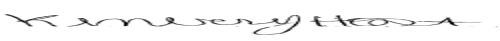
Ms. Calvin reported Resident C has a history of combativeness with staff members and residents. Ms. Calvin reported if Resident C is combative, staff members are to bring another caregiver in the room or come back later to provide care.

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(5) A home shall update each resident's service plan at least annually or if there is a significant change in the resident's care needs. Changes shall be communicated to the resident and his or her authorized representative, if any.
ANALYSIS:	Review of Resident C's service plan revealed lack of detail on behaviors of Resident C and lack of instruction for staff to follow when Resident C is combative.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 2/26/2023, I conducted an exit conference Louis Andriotti, Jr by telephone.

IV. RECOMMENDATION

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



1/27/2023

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Kimberly Horst — Date
Licensing Staff

Approved By:

02/06/2023

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