GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

November 27, 2023

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

RE: License #: AH410397992
Investigation #: 2024A1028008
Vista Springs Wyoming

Dear Louis 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

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

I. IDENTIFYING INFORMATION

License #:	AH410397992
Investigation #:	2024A1028008
Complaint Receipt Date:	10/24/2023
Investigation Initiation Date:	10/26/2023
Report Due Date:	12/23/2023
Licensee Name:	Vista Springs Wyoming LLC
Licensee Address:	Ste 110 2610 Horizon Dr. SE Grand Rapids, MI 49546
Licensee Telephone #:	(616) 259-8659
Administrator:	Jessica Hunter
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:	06/10/2023
Expiration Date:	06/09/2024
Capacity:	147
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Facility staff did not provide appropriate care for Resident A in a timely manner.	Yes
Resident A incurred a fall resulting in injury due to a care staff member's unsafe transfer technique.	Yes
Additional Findings	Yes

III. METHODOLOGY

10/24/2023	Special Investigation Intake 2024A1028008
10/26/2023	Special Investigation Initiated - Letter
10/26/2023	APS Referral APS referral made to Centralized Intake
11/08/2023	Contact - Face to Face Interviewed Employee A at the facility.
11/08/2023	Contact - Face to Face Interviewed Employee B at the facility.
11/08/2023	Contact - Face to Face Interviewed Employee C at the facility.
11/08/2023	Contact - Document Received Received Resident A's limited record from staff.

ALLEGATION:

Facility staff did not provide appropriate care for Resident A in a timely manner.

INVESTIGATION:

On 10/24/2023, the Bureau received the allegations through the online complaint system.

On 10/24/2023, Adult Protective Services (APS) made referral to Homes for the Aged (HFA) through Centralized Intake.

On 11/8/2023, I interviewed Employee A at the facility who reported Resident A was sent to the hospital on 8/2/2023 due to demonstrating slurred speech and discomfort from a heel wound. Resident A returned from the hospital the same day but on 8/5/2023 Resident A was sent to the hospital again due to a fall resulting in injury. Resident A returned from the hospital 8/8/2023 with physician orders for treatment of closed fracture of the left leg. Employee A reported the hospital did not have a skilled placement for Resident A and the facility agreed to take Resident A back and to assist the guardian with obtaining a skilled placement for Resident A. Employee A reported [they] are unsure why Resident A could not obtain a skilled nursing placement while at the hospital and could not provide any further details. However, upon return to the facility on 8/8/2023, Resident A continued to demonstrate a significant decline to include unresponsiveness and foaming at the mouth. Resident A passed away a few hours later at the facility.

On 11/8/2023, I interviewed Employee B at the facility whose statements were consistent with Employee A's statements.

On 11/8/2023, I requested Resident A's record with Employee A and Employee B stating since there was a recent management change on 11/1/2023, staff no longer have access to the prior records. However, Employee A and Employee B were able to provide me with a paper copy of Resident A's limited record for my review.

On 11/8/2023, I reviewed Resident A's record which revealed the following:

- History of falls, muscle weakness, and age-related osteoporosis.
- Abnormalities of gait and mobility, lack of coordination, morbid (severe) obesity and history of localized edema.
- Hemiplegia and hemiparesis following cerebral infarction.
- Acute respiratory failure, unspecified.
- Hypertension, venous insufficiency (chronic and peripheral), diverticulosis of the intestine unspecified and other co-morbidities.
- Major depressive disorder, altered mental status, unspecified dementia with behavioral disturbance, and unspecified convulsions.
- Incident Report from 8/5/2023 but dated file completion is 8/8/2023 which revealed Resident A tried to get up from the edge of bed to transfer to the wheelchair with staff assisting. Staff members legs buckled with Resident A being "laid on the floor". Vitals were taken and "all parties were notified". Another staff member was called to assist Resident A from the floor due to morbid obesity and Resident A was sent to hospital for further evaluation.
- No documentation was found in the record for Resident A's incident and subsequent hospital visit on 8/2/2023.
- An observation reported was completed by facility staff on 4/22/2023 detailing a fall.

- An observation report was completed by facility staff on 5/26/2023 detailing Resident A's change in mood.
- An observation report was completed on 8/8/2023 detailing Resident A was unresponsive and foaming at the mouth.

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.**
ANALYSIS:	It was alleged Resident A was sent to the hospital on 8/2/2023 due to slurred speech and due to demonstrating discomfort from a wound on heal. Interviews confirmed Resident A was sent to the hospital on 8/2/2023 and returned the same day. Resident A was sent again to the hospital on 8/5/2023 due to a fall resulting in a left leg fracture. Resident A required skilled nursing services after the 8/5/2023 hospitalization, but facility staff interviewed reported a placement could not be obtained upon discharge from the hospital. Facility staff reported they are unsure why a placement could not be obtained and could not provide any further details due to having no access to prior records. The facility agreed to assist Resident A's guardian with finding a skilled placement for Resident A. Upon return to the facility on 8/8/2023, Resident A demonstrated a significant decline and subsequently passed away a few hours later at the facility. Interviews and review of Resident A's limited record reveal no evidence of facility staff appropriately supervising or assisting Resident A upon either return from the hospital on 8/2/2023 or 8/8/2023. There is also no evidence Resident A was appropriately monitored upon return from the hospital to the facility and prior to being found unresponsive and foaming at the mouth at 5:39pm on 8/8/2023. Therefore, the facility is in violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A incurred a fall resulting in injury due to a care staff member's unsafe transfer technique.

INVESTIGATION:

On 11/8/2023, Employee A confirmed Resident A incurred a fall on 8/5/2023 with one care staff member present. Resident A attempted to get up from the edge of bed to transfer to the wheelchair with one care staff member assisting. The care staff member's legs buckled, and Resident A was placed on the floor. The care staff member called for assistance from another staff member to assist Resident A up from the floor due to Resident A's morbid obesity. Resident A was sent to the hospital for further evaluation and was subsequently diagnosed with a fracture of the left leg.

On 11/8/2023, Employee B's statements was consistent with Employee A's statements.
On 11/8/2023, I requested Resident A's service plan, but it could not be found due to a recent management change on 11/1/2023 which resulted in staff no longer having access to resident records. However, I was provided with a limited record for Resident A which revealed the following:

- Incident reported dated 8/5/2023, but file completion dated 8/8/2023 confirmed Employee A's statement about the fall with injury.
- Resident A had a history of falls, muscle weakness, and age-related osteoporosis.
- Resident A had abnormalities of gait and mobility, lack of coordination, morbid (severe) obesity and history of localized edema.
- Resident A had a history of hemiplegia and hemiparesis following cerebral infarction.
- No service plan was found in the limited record for Resident A.

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 Resident A fell on 8/5/2023 resulting in a left leg fracture. Interviews and review of documentation reveal only one care staff member attempted to assist Resident A during a transfer from edge of bed to the wheelchair with the care staff member's legs buckling resulting in Resident A falling and sustaining a left leg fracture. Interviews and review of limited documentation also reveal Resident A has a diagnosis of morbid (severe) obesity, history of falls, hemiplegia, hemiparesis, abnormalities of gait and mobility and lack of coordination etc. It was also revealed only one staff member attempted to assist Resident A during the transfer, but two staff members were required to assist Resident A from the floor after the fall. It cannot be determined if the two care staff members or if emergency services assisted Resident A up from the floor due to the incomplete documentation of the incident. Care staff did not provide appropriate assistance or supervision pertaining to Resident A's medical history or current physical condition when assisting Resident A during transfers which resulted in a fall with injury. Therefore, the facility is in violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

Additional Findings:

INVESTIGATION:

On 11/8/2023, it was discovered there is not a current administrator onsite that is appointed to oversee the operation of the facility. When interviewed, Employee A, Employee B, and Employee C were all unaware the facility has five days to notify the department of any changes in information pertaining to the license.

APPLICABLE RULE	
R 325.1913	**Licenses and permits; general provisions.**
	(2) The applicant or the authorized representative shall give written notice to the department within 5 business days of any changes in information submitted in the application pursuant to which a license, provisional license, or temporary nonrenewable permit has been issued.

ANALYSIS:	The administrator currently listed no longer works as the administrator for the facility and has not been in the administrator role since September 2023. The facility applicant and/or facility authorized representative did not notify the department of the vacancy or role change within 5 days and has not appointed a new administrator either. Therefore, the facility is in violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

On 11/8/2023, it was discovered during facility staff interviews that Jessica Hunter, who is listed as the current administrator has not worked in the administrator role since September 2023. Employee A, Employee B, and Employee C were unable to provide an exact date in September 2023. There is no one currently fulfilling the administrator position at the facility.

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 a competent administrator who is responsible for operating the home in accordance with the established policies of the home.**
ANALYSIS:	Interviews revealed that Jessica Hunter, who is listed as the facility administrator, has not worked as the administrator for the facility since September 2023. It was also revealed Jessica Hunter works in a corporate position at the corporate office now. The facility owner, operator, and governing body has a responsibility to appoint an administrator who is responsible for the operation of the home. As of 11/27/2023, an administrator still has not been appointed.
CONCLUSION:	**VIOLATION ESTABLISHED**

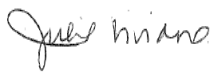
INVESTIGATION:

On 11/8/2023, it was discovered that upon the recent management change on 11/1/2023, facility staff no longer had access to prior resident records, so information I requested either could not be provided and/or only very limited information was provided. Of the very limited record information that was provided to me, some of the reports were not dated or signed either.

APPLICABLE RULE	
R 325.1942	**Resident Records**
	(1) A home shall assure that a current resident record is maintained and that all entries are dated and signed.
ANALYSIS:	The facility is to maintain a current resident record and all entries are to be signed and dated. The facility does not have current records for the residents and the limited records the facility does have are incomplete. Therefore, the facility is in violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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



11/27/2023

_____

Julie Viviano Date
Licensing Staff

Approved By:

01/09/2024

_____

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