GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

November 28, 2023

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

RE: License #: AH410397992
Investigation #: 2024A1028012
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 #:	2024A1028012
Complaint Receipt Date:	10/26/2023
Investigation Initiation Date:	10/30/2023
Report Due Date:	12/25/2023
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:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
The facility did not provide Resident A appropriate care or supervision in accordance with the service plan.	Yes
Additional Findings	Yes

III. METHODOLOGY

10/26/2023	Special Investigation Intake 2024A1028012
10/30/2023	Special Investigation Initiated - Letter
10/30/2023	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 record from staff.

Please be advised that limited resident record information was obtained during this investigation due to the facility no longer having access to prior resident records as of 11/1/2023. The facility was cited for the record violation in special investigation 2024A1028008.

ALLEGATION:

The facility did not provide Resident A appropriate care or supervision in accordance with the service plan.

INVESTIGATION:

On 10/26/2023, the Bureau received the allegations through the online complaint system.

On 11/8/2023, I interviewed Employee A at the facility who reported Resident A passed away in July and [they] have no knowledge of Resident A not receiving care in accordance with the service plan. Employee A reported no knowledge of Resident A not receiving care for 48 hours during the 2022 New Year holiday weekend or Resident A being left to sit in urine and/or feces for 12 hours. Resident A was receiving hospice services prior to passing and the facility communicated regularly with the hospice team and Resident A's family. Employee A provided me Resident A's limited record for my review.

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

On 11/8/2023, I interviewed Employee C at the facility, but Employee C was unable to provide any knowledge about the allegations.

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

- Resident A has a diagnosis of progressive vascular dementia, peripheral edema, Generalize Anxiety Disorder (GAD), Gastroesophageal Reflux Disease (GERD), Major Depressive Disorder (MDD), and is a high fall risk.
- *History of stroke, sleeps a lot, beginning to drag foot now.*
- *Family defers all treatment except for Celexa and Lasix.*

Review of limited hospice documentation revealed the following:

- Evidence of hospice services documentation dating back to September 2022.
- On 9/8/2022, a routine hospice MSW *visit was completed with collaboration with [facility staff] and no concerns. Continue POC.*
- On 10/5/2022, a routine hospice MSW *visit was completed. Provided support in the dining room with patient. LLMSW collaborated with facility staff. No concerns. Continue with plan of care.*
- On 1/18/2023, *Senna was discharged, and Senna-S BID was started. Hold for loose stools per Dr. Tallen*.
- On 3/30/2023, a hospice nurse visit was completed, and the following was communicated to the facility: *Please ensure hot chocolate is served to patient already mixed R/T. [Resident A] has tried to eat dry mix causing cough. If family is not present and feeding her at meals, please assist patient eating.*
- On 4/17/2023, a hospice clinician was completed with Resident A *eating well, no pain, patient sleeping.*
- On 4/20/2023, a hospice nursing PRN visit was completed due to change in condition. [Resident A's*] O2 had been in the 60s. O2 was 78% at this visit. [Resident A] is completed unresponsive. HR irregular. Plan discussed with [family]. No need for O2 at this time. Collaboration with [facility staff]. Visit tomorrow to assess comfort and decline.*
- On 4/21/2023, a hospice nursing visit was completed. Lasix was discharged. Bumex was started. Dexamethasone was started for 3 days due to respiratory inflammation per Dr. Tallen.

- On 4/23/2023, a hospice nursing visit was completed. *Morphine as needed started for increased respiratory rate. Dressing changed on right leg. Updated [family] regarding [Resident A's] decline. Monday call if visit needed sooner.*
- On 4/26/2023, a hospice nurse visit was completed, and the following was communicated to the facility: *Please ensure heels are "floated" elevated above bed with folded blanket or pillow. Turn left/right/middle every 2 hours. Apply Z-guard barrier cream after each incontinence episode.*

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 that Resident A was not provided appropriate care or supervision in accordance with the service plan for 48 hours during the 2022 New Year holiday weekend. It was also alleged Resident A was left to sit in urine and feces for 12 hours (no date provided). Interviews and review of documentation reveal while there is no evidence to support these allegations. However, there is evidence to support facility did not provide Resident A with appropriate care, supervision, or safety on 3/30/2023. A hospice nursing visit on 3/30/2023 documented that Resident A ate dry hot chocolate mix which resulted in a cough and that facility staff will need to assist Resident A with eating if family is unavailable to. Review of Resident A's medical history also notates that Resident A has a history of Gastroesophageal Reflux Disease (GERD) which requires management and documented history of respiratory inflammation and distress on 4/20/2023, 4/21/2023, and 4/23/2023. On 4/26/2023, it was also noted in a hospice nursing visit that facility staff needed to ensure Resident A's heels were floated and elevated. The facility did not provide appropriate care, supervision, or safety for Resident A in March 2023 resulting in Resident A eating dry hot chocolate mix resulting in a cough. Appropriate care was not provided to Resident A in April 2023, as hospice documentation revealed Resident A's heels were not floated consistently by facility staff. Therefore, the facility is in violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

Additional Findings:

INVESTIGATION:

On 11/8/2023, I requested Resident A's service plan, and it could not be provided as requested due to the facility no longer having access to resident records prior to 11/1/2023.

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:	The facility was unable to provide a current and up to date service plan for Resident A when requested. Therefore, the facility is in violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Julie Viviano

11/28/2023

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Julie Viviano Date
Licensing Staff

Approved By:

01/09/2024

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