GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

March 7, 2022

Judy Amiano
Rivertown Ridge
3555 Copper River Ave. SW
Wyoming, MI 49418

RE: License #: AH410393434
Investigation #: 2022A1010023
Rivertown Ridge

Dear Mrs. Amiano:

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 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) 241-1970.

Sincerely,

Lauren Wohlfert, Licensing Staff
Bureau of Community and Health Systems
350 Ottawa NW Unit 13, 7th Floor
Grand Rapids, MI 49503
(616) 260-7781
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH410393434
Investigation #:	2022A1010023
Complaint Receipt Date:	02/02/2022
Investigation Initiation Date:	02/04/2022
Report Due Date:	04/04/2022
Licensee Name:	Traditions at Rivertown Park, LLC
Licensee Address:	3330 Grand Ridge Drive NE Grand Rapids, MI 49525
Licensee Telephone #:	(331) 318-5111
Administrator:	Eric Kirby
Authorized Representative:	Judy Amiano
Name of Facility:	Rivertown Ridge
Facility Address:	3555 Copper River Ave. SW Wyoming, MI 49418
Facility Telephone #:	(616) 258-2727
Original Issuance Date:	02/11/2020
License Status:	REGULAR
Effective Date:	08/11/2021
Expiration Date:	08/10/2022
Capacity:	76
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
The facility is not following Resident A's hospice orders.	Yes

III. METHODOLOGY

02/02/2022	Special Investigation Intake 2022A1010023
02/04/2022	Contact - Telephone call made Interviewed complainant by telephone
02/04/2022	APS Referral APS referral emailed to Centralized Intake
02/04/2022	Contact - Document Received Received resident's hospice orders via email
02/04/2022	Special Investigation Initiated - Telephone Interviewed the complainant by telephone
02/09/2022	Inspection Completed On-site
02/09/2022	Contact - Document Received Received resident's service plan and hospice documents
03/07/2022	Exit Conference Completed with administrator and message left for licensee authorized representative Judy Amiano

ALLEGATION:

The facility is not following Resident A's hospice orders.

INVESTIGATION:

On 2/2/22, the Bureau received the allegations from the online complaint system. The complaint read Resident A fell and broke her hip. She was admitted to the hospital and the complaint read, "At the time of discharge from the hospital the facility stated they were equipped to handle a bed bound patient. Since patient has

been admitted back to her care she has developed 1 pressure sore and accelerated another. The facility will not get patient out of her bed (ever).” Hospice attempted to order a hoyer lift for Resident A, however the facility stated “they are a ‘no lift facility.’’ Resident A is left alone in her room with the door closed all day and all night. Staff have ignored multiple written hospice orders for Resident A to be placed into a chair daily. Resident A is deaf and partially blind and “staff does not set up a bedside tray over her, so she can have access to water.”

On 2/4/22, I emailed an Adult Protective Services (APS) referral to Centralized Intake.

On 2/4/22, I interviewed the complainant by telephone. The complainant statements were consistent with the written complaint the Bureau received. The complainant expressed concern that Resident A is left isolated in her bed daily because staff refuse to follow her hospice order to be placed in a chair. The complainant reported Resident A can be transferred to a chair with the use of a hoyer lift per her hospice orders, however the facility stated there are “a no lift facility.” The complainant said Resident A should not be at the facility if they do not allow the use of a hoyer lift for transfers.

The complainant stated staff are also not “floating” Resident A’s heels per a hospice order. The complainant reported Resident A developed an ulcer on her heels as a result. The complainant has witnessed Resident A in bed multiple times with her heels on her mattress and not “floated” as ordered.

The complainant reported “bolsters” were also ordered for Resident A’s bed. The complainant explained the “bolsters” were not immediately placed on Resident A’s bed and she fell out of it as a result. The complainant said Resident A’s bedside tray is often not placed over Resident A while she is in bed. The complainant stated as a result Resident A cannot reach her water and often asks for a drink as a result.

On 2/4/22, I emailed an Adult Protective Services referral to Centralized Intake.

On 2/4/22, I received Resident A’s West Michigan Hospice *VERBAL ORDER* documents via email for my review. An order dated 1/18/22 read, “Please get patient out of bed and into a chair once daily.” This order was signed by Resident A’s West Michigan Hospice physician. An order dated 1/24/22 read, “Please discontinue use of Calcium Alginate on heels as there is no longer any discharge. Please elevate heels at all times. Please get patient out of bed at least once daily into a chair and sit in the common area for social interaction. When patient is in bed, please place bedside table over patients [sic] bed with water at arms [sic] reach so patient has access to water at all times.” This order was signed by Resident A’s West Michigan Hospice registered nurse (RN).

An order dated 1/26/22 read, “Please d/c dressing changes on left heel. Please utilize air boots that will be supplied from WMH. Please use bed bolsters to help

keep patient from falling out of bed." This order was signed by Resident A's West Michigan Hospice physician.

On 2/9/22, I interviewed director of resident services Tarita Dooley at the facility. Ms. Dooley reported staff at the facility are not trained how to use a hoyer lift assistive device to transfer residents. Ms. Dooley stated as a result, residents who require the use of a hoyer lift to transfer are not admitted to the facility. Ms. Dooley reported staff can transfer Resident A with the assistance of two staff persons without the use of a hoyer lift.

Ms. Dooley stated staff attempted to follow Resident A's hospice order to transfer her to a chair daily, however there were instances when Resident A refused to comply. Ms. Dooley reported Resident A verbally refused and has a history of becoming physically combative with staff.

Ms. Dooley reported bolster were ordered for Resident A's bed, however Resident A's name was not on them when they arrived at the facility. As a result, staff did not know who they belonged to. Ms. Dooley reported she located the bolsters that were misplaced by staff and they were then placed on Resident A's bed. Ms. Dooley stated Resident A did fall out of bed once when the bolsters were not in place, however she was not harmed or injured in the incident.

Ms. Dooley said Resident A developed a pressure ulcer on her buttocks when she was in the hospital. Ms. Dooley reported staff do not complete dressing changes, hospice staff treat the ulcer. Ms. Dooley explained a hospice aide and nurse are in the facility to see Resident A twice a week. Ms. Dooley stated staff check on Resident A often and adjust her in bed when they change her. Ms. Dooley said Resident A has a catheter in place.

Ms. Dooley reported Resident A's tray table is kept on the side of her bed or in front of her. Ms. Dooley stated Resident A had a history of hitting her limbs on the tray table when it was placed over her. Ms. Dooley said Resident A has access to water and is able to communicate with staff when she is thirsty.

Ms. Dooley provided me with a copy of Resident A's service plan for my review. The *Transferring* section of the plan read, "1-2 ASSIST Rivertown Ridge Care Staff to assist with all transfers. [Resident A] is able to bear weight however, she is deconditioned and very weak. When transferring to Broda Chair staff to use 2 staff members to complete safe transfer." The *Ambulation/Mobility* section of the plan read, "Rivertown Ridge staff to use Broda chair for mobility."

The *Behavior* section of the plan read, "[Resident A] exhibits agitation and may yell out 'Help' Staff to explain what they are doing and redirect [Resident A] in moments of agitation. If staff is unable to deescalate behaviors staff to step away and re-approach. If re-approach is not successful staff to employ team member to assist in care. If team member cannot assist NOTIFY Medtech and Nurse on duty." The

Other section of the plan read, "[Resident A] receives services from West Michigan Hospice. Hospice services are provided 2 times weekly and on the weekend for wound care. Stage 2 Wound on buttock. Cared for by West Michigan Hospice."

Ms. Dooley provided me with Resident A's hospice staff notes for my review. Notes dated 1/17/22, 2/4/22, and 2/8/22 read hospice staff provided wound care treatment for Resident A.

On 2/9/22, I interviewed medication technician (med tech) Sandra Ostojic at the facility. Ms. Ostojic's statements regarding Resident A's tray table, wound care by hospice staff, Resident A's behaviors and bed bolsters were consistent with Ms. Dooley.

Ms. Ostojic reported staff cannot safely transfer Resident A with the assistance of two staff persons. Ms. Ostojic stated she has observed firsthand that Resident A cannot bear weight, therefore staff cannot transfer her. Ms. Ostojic stated staff would be able to safely transfer Resident A with the use of a hoyer lift as hospice ordered, however the facility is "a no lift facility." Ms. Ostojic said staff were not trained to use a hoyer lift assistive device because the facility does not admit residents who require their use. Ms. Ostojic reported the hospice order to put Resident A in a chair during the day is not being followed because staff are unable to transfer her. Ms. Ostojic stated as a result, Resident A's needs would be better met in a skilled nursing facility.

On 2/9/22, I attempted to interview Resident A at the facility. I was unable to engage Resident A in meaningful conversation. I observed Resident A's tray table was over her while she was positioned upright in her bed. I observed a full cup of water on the tray table within reach of Resident A. Resident A was alert, however communication with her was very difficult due to her difficulty hearing.

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:	The interview with the complainant, along with review of Resident A's hospice orders revealed she was to be transferred to a chair daily with the use of a hoyer lift. The interview with Ms. Dooley revealed the facility cannot accommodate residents who require the use of a hoyer lift to transfer. Ms. Dooley reported staff were not trained to use this assistive device. The interview with Ms. Ostojic revealed staff cannot transfer Resident A without the use of a hoyer lift because Resident A cannot bear weight. The facility has not been following Resident A's hospice orders and therefore is not providing care consistent with her ordered hospice services.
CONCLUSION:	**VIOLATION ESTABLISHED**

I shared the findings of this report with administrator Eric Kirby by telephone on 03/07/2022. Mr. Kirby reported Resident A passed away this morning. Mr. Kirby and I discussed the need for the facility to admit and maintain residents whose needs staff can be sure to meet consistent with their service plans and any outside service provider orders. I left a telephone message for licensee authorized representative Judy Amiano on 03/07/2022.

IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

02/22/2022

Lauren Wohlfert Date
Licensing Staff

Approved By:

03/07/2022

Andrea Moore Date
Area Manager