GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 22, 2022

Karen Larson
Rivertown Ridge
3555 Copper River Ave. SW
Wyoming, MI 49418

RE: License #:	AH410393434
Investigation #:	2022A1021058
	Rivertown Ridge

Dear Mrs. Larson:

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) 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 #:	AH410393434
Investigation #:	2022A1021058
Complaint Receipt Date:	09/02/2022
Investigation Initiation Date:	09/02/2022
Report Due Date:	11/02/2022
Licensee Name:	Traditions at Rivertown Park, LLC
Licensee Address:	3330 Grand Ridge Drive NE Grand Rapids, MI 49525
Licensee Telephone #:	Unknown
Administrator:	Eric Kirby
Authorized Representative/	Judy Amiano
Name of Facility:	Rivertown Ridge
Facility Address:	3555 Copper River Ave. SW Wyoming, MI 49418
Facility Telephone #:	Unknown
Original Issuance Date:	02/11/2020
License Status:	REGULAR
Effective Date:	08/11/2022
Expiration Date:	08/10/2023
Capacity:	76
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Lack of personal protective equipment for staff members.	No
There is insufficient staff at the facility.	Yes
Additional Findings	No

III. METHODOLOGY

09/02/2022	Special Investigation Intake 2022A1021058
09/02/2022	Special Investigation Initiated - Letter allegations sent to APS
09/06/2022	Inspection Completed On-site
11/22/2022	Exit Conference Karen Larson

ALLEGATION:
There is lack of personal protective equipment for staff members.

INVESTIGATION:
On 9/2/22, the licensing department received an anonymous complaint with allegations the facility has lack of personal protective equipment. Due to the anonymous complaint, I was unable to contact the complainant for additional information.

On 9/2/22, the allegations in this report were sent to centralized intake at Adult Protective Services (APS).

On 9/6/22, I interviewed the administrator Eric Kirby at the facility. Mr. Kirby reported there was a recent Covid-19 outbreak at the facility. Mr. Kirby reported residents in assisted living and memory care were affected and a few staff members. Mr. Kirby reported the facility has N95 masks, face shields, gowns, shoe booties, and gloves for caregivers. Mr. Kirby reported the supplies are located on each floor and outside the door of a resident that is Covid-19 positive. Mr. Kirby reported the facility never ran out of supplies or been without supplies.

On 9/6/22, I interviewed director of nursing Tarita Dooley at the facility. Ms. Dooley reported the facility has sufficient supply of personal protective equipment (PPE). Ms. Dooley reported when a resident tests positive for Covid-19, a cart is placed

outside the resident's room with the necessary equipment. Ms. Dooley reported caregivers are to put on the equipment prior to entering the room and then remove the equipment. Ms. Dooley reported the facility has wipes to wipe down door handles and the door of the resident that has Covid-19. Ms. Dooley reported the facility has sufficient supply of PPE.

On 9/6/22, I interviewed staff person 1 (SP1) at the facility. SP1 reported the facility always has had sufficient PPE. SP1 reported the equipment is located on each floor and by resident's room.

On 9/6/22, I interviewed SP2 at the facility. SP2 reported there is sufficient supply of PPE at the facility. SP2 reported the equipment is available for all staff members.

While onsite, I observed in the memory care and assisted living units, PPE located in a storage closet and by the medication carts. Within the unit, there was boxes of N95 masks, face shields, gowns, shoe booties, and gloves. I observed a resident that was Covid-19 positive. Outside of the resident's room there was a cart with PPE, gloves, and instructions for the staff member on PPE.

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:	Interviews conducted at the facility and observations made revealed the facility has adequate and sufficient supply of PPE for caregivers. There is lack of evidence to support this allegation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:
There is insufficient staff at the facility.

INVESTIGATION:
The complainant alleged the building is very unstaffed.

Mr. Kirby reported the facility is currently using agency staff to fill open shifts. Mr. Kirby reported the facility does not mandate and will attempt to fill open shifts with offering over time to employees. Mr. Kirby reported management will work the floor, if needed. Mr. Kirby reported the facility is hiring for all shifts.

On 9/6/22, I interviewed facility scheduler Pazundra Chandler at the facility. Ms. Chandler reported on first and second shift in the memory care unit there is to be two caregivers with a medication technician. Ms. Chandler reported in the assisted living unit on first and second shift there is to be one medication technician and two caregivers working in the entire assisted living unit. Ms, Chandler reported the assisted living unit is spread out over two floors. Ms. Chandler reported the caregivers are responsible for residents on both floors. Ms. Chandler reported on third shift there is to be one caregiver in each unit and a medication technician that floats between the units. Ms. Chandler reported the facility does not mandate for caregivers to stay over their end shift time or come in early. Ms. Chandler reported if a caregiver no shows for their shift, it can be difficult to get the shift covered. Ms. Chandler reported management will work the floor, if needed. Ms. Chandler reported there is at least one call off for each shift multiple times a week. Ms. Chandler reported the facility has agency staff in the facility on every shift and every day. Ms. Chandler reported the agency staff workers are not reliable and the facility is transitioning to using a different agency company that is more reliable.

Ms. Dooley reported there are 14 residents in memory care. Ms. Dooley reported there is one resident with a catheter and some residents with behaviors. Ms. Dooley reported there are 28 residents in assisted living. Ms. Dooley reported the assisted living unit is on two different floors. Ms. Dooley reported there are two residents that are a two person assist, one resident that has frequent falls, and one resident that is on oxygen. Ms. Dooley reported when a caregiver calls off for their shift, management will work the floor until the shift is covered. Ms. Dooley reported management will work the floor approximately once or twice a week.

SP1 reported the facility is currently using agency staff but at times the staff do not show up for their shift. SP1 reported management will work the floor as needed. SP1 reported medications are late at times due to the lack of staff and the medication technician helping the caregivers with the care needs of the resident.

SP3 reported it is typical for the facility to work short staffed due to caregivers not showing up for their shift. SP3 reported the start of the shift is the busiest because of unplanned calls off and management working to find replacement staff. SP3 reported call lights are on for increased time due to lack of staff. SP3 reported caregivers use telephones to communicate between each other but at times they do not work which results in the caregiver walking throughout the two-story facility to find another caregiver. SP3 reported in assisted living there three residents that are a two person assist and at times they are transferred using only one person.

I walked the assisted living unit. The unit was located on the second and third floor of the facility. Within each floor, the elevators open to a common area with the resident rooms in a L shape. There are residents located on both the second and third floor. Staff members can utilize the stairs or the elevators to move from floor to floor. To walk from the northeast portion of the second floor to the northwest portion of third floor, takes on average five minutes.

I reviewed Resident A's service plan. The service plan read,

"(Resident A) requires assistance from 2 staff members to safety transfer to the toilet."

I reviewed Resident B's service plan. The service plan read,

"(Resident B) will complete transfers with the assistance of 1-2 people/lift devices as required."

I reviewed Resident C's service plan. The service plan read,

"(Resident C) will have toileting needs met with the assistance of 1-2 people."

I reviewed the staff schedule for 8/21-9/3. The schedule revealed in assisted living on the following shifts there were only three people working in the entire assisted living unit:

8/21 first shift
8/22 first shift
8/23 first shift
8/24 first shift
8/25 first shift
8/25 second shift
8/26 first shift
8/28 first shift
8/28 second shift
8/29 first shift

8/30 first shift
9/1 first shift
9/1 second shift
9/2 second shift
9/3 first shift
9/3 second shift

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(5) The home shall have adequate and sufficient staff on duty at all times who are awake, fully dressed, and capable of providing for resident needs consistent with the resident service plans.
ANALYSIS:	Reviews of resident service plans revealed in assisted living unit there is one resident that is a two person assist and two residents that are a one to two person assist. The assisted living unit is spread out over two floors with residents on each floor. Review of staff schedule revealed there are multiple shifts in which there are only two caregivers for the entire assisted living unit. This practice of staffing insufficient caregivers' results in an increased risk of harm to the residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 11/22/22, I conducted an exit conference with authorized representative Karen Larson by telephone.

IV. RECOMMENDATION

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

Kimberly Horst 9/28/22

Kimberly Horst Date
Licensing Staff

Approved By:
Andrea L. Moore 11/17/2022

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