GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

November 30, 2023

Eric Kirby
Rivertown Ridge
3555 Copper River Ave. SW
Wyoming, MI 49418

RE: License #: AH410393434
Investigation #: 2024A1021004
Rivertown Ridge

Dear Mr. Kirby:

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 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

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 #:	2024A1021004
Complaint Receipt Date:	10/12/2023
Investigation Initiation Date:	10/13/2023
Report Due Date:	12/11/2023
Licensee Name:	Traditions at Rivertown Park, LLC
Licensee Address:	3330 Grand Ridge Drive NE Grand Rapids, MI 49525
Licensee Telephone #:	Unknown
Administrator/ Authorized Representative:	Eric Kirby
Name of Facility:	Rivertown Ridge
Facility Address:	3555 Copper River Ave. SW Wyoming, MI 49418
Facility Telephone #:	(616) 580-1098
Original Issuance Date:	02/11/2020
License Status:	REGULAR
Effective Date:	08/11/2023
Expiration Date:	08/10/2024
Capacity:	76
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A received incorrect medication.	No
Additional Findings	Yes

III. METHODOLOGY

10/12/2023	Special Investigation Intake 2024A1021004
10/13/2023	Special Investigation Initiated - Telephone interviewed administrator by telephone
10/13/2023	Contact - Telephone call made interviewed SP1
10/17/2023	Contact-Document Received Received Resident A's documents
11/30/2023	Exit Conference

ALLEGATION:

Resident A received incorrect medication.

INVESTIGATION:

On 10/12/2023, the licensing department received a complaint with allegations Resident A received incorrect medication which caused Serotonin Syndrome.

On 10/13/2023, I interviewed authorized representative Eric Kirby by telephone. Mr. Kirby reported that Resident A was a resident of the memory care unit and moved out on 09/23/2023, Mr. Kirby reported that there was one medication error that occurred. Mr. Kirby reported the medication error was investigated, the medication technician was removed from administering medications, and the appropriate parities was notified. Mr. Kirby reported the medication error was an isolated incident and only occurred once.

On 10/13/2023, I interviewed staff person 1 (SP1) by telephone. SP1 reported Resident A had changes in the dose of the Celexa medication. SP1 reported the facility uses the Right Pack system to administer medications. SP1 reported when the medication dose changed, the Right Pack had the 40mg tablet and the 20mg

tablet, but Resident A was only to receive the 20 mg tablet. SP1 reported the facility was aware but did not want to open each Right Pack to remove the extra tablet. SP1 reported the medication technicians were aware that there was an extra pill in the Right Pack. SP1 reported when a medication technician administers medications, they are to open the pack and review the pills prior to administering. SP1 reported on 08/20/2023, the medication technician did not review the medications and administered the 40mg tablet and the 20mg tablet to Resident A. SP1 reported the medication technician realized the error and reported the error to the shift supervisor. SP1 reported Resident A's physician was made aware and the facility was to observe for any changes with Resident A. SP1 reported Resident A's family was present in the facility and were notified in person. SP1 reported she contacted the pharmacy and Serotonin Syndrome could not occur after this isolated medication error. SP1 reported the medication technician was immediately removed from administering medications and was provided additional training.

I reviewed September 2023 medication administration record (MAR) for Resident A. The MAR read,

> *"Celexa Oral tablet 20mg start 08/16/2023 end 08/22/2023 with instructions to give 20mg by mouth one time a day."*
> *"Celexa Oral tablet 40mg start 08/23/2023 end 09/23/2023 with instructions to give one tablet by mouth one time a day."*

I reviewed incident report completed for the medication error. The narrative read,

> *"A member of the workforce assigned and trained to administer medications failed to perform 3 checks to confirm that the resident was receiving the correct medication and dosage. Medication error ensued. Incorrect dose was given. Resident unable to give description. Doctor was notified and Director of Nursing was also notified of error to determine next steps. Multiple changes in the medications. Resident meds were sent by Hometown Pharmacy dosage change was reflected in the orders but not in the prepackaged medications that were sent."*

I reviewed SP2's *Corrective Action Plan* for the medication error. The narrative read,

> *"8/20/23: (SP2) reported that medication Celexa 40mg and 20mg were in Right Pack for resident. Order states Resident to receive 20mg. Resident receive 40mg and 20mg = 60mg one time in total. (SP2) was removed from med pass for upcoming shifts and re-educated on 5 rights and proper med pass. Observation by (SP3) and (SP4). Counseling took place 9/7/23."*

APPLICABLE RULE

R 325.1932	**Resident medications.**
	(2) Prescribed medication managed by the home shall be given, taken, or applied pursuant to labeling instructions, orders and by the prescribing licensed health care professional.
ANALYSIS:	On 08/20/2023, Resident A received incorrect dose of Celexa medication. Upon discovery of the error, the facility immediately contacted Resident A's physician and family. In addition, the medication technician was removed from administering medications and received additional education. While this error did not occur, it was an isolated incident, and it is not a systemic issue throughout the facility.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

SP1 reported SP2 was trained in medication administration.

Review of SP2's employee record revealed lack of documentation that SP2 was trained in medication administration.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(6) The home shall establish and implement a staff training program based on the home's program statement, the residents service plans, and the needs of employees, such as any of the following: **(g) Medication administration, if applicable.**
ANALYSIS:	Review of SP1's employee record revealed lack of documentation that SP1 was trained in medication administration.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

10/31/2023

Kimberly Horst Date
Licensing Staff

Approved By:

11/30/2023

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