GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

December 19, 2023

Rita Kumar
Riverdale Assisted Living and Memory Care LLC
Suite 300
28592 Orchard Lake Rd.
Farmington Hills, MI 48334

RE: License #: AL500402308
Investigation #: 2024A0617005
Riverdale Assisted Living & Memory Care

Dear Ms. Kumar:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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.

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 (248) 975-5053.

Sincerely,

Eric Johnson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste 9-100
3026 W Grand Blvd.
Detroit, MI 48202

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT
CAUTION: THIS REPORT CONTAINS PROFANITY

I. IDENTIFYING INFORMATION

License #:	AL500402308
Investigation #:	2024A0617005
Complaint Receipt Date:	11/02/2023
Investigation Initiation Date:	11/02/2023
Report Due Date:	01/01/2024
Licensee Name:	Riverdale Assisted Living and Memory Care LLC
Licensee Address:	Suite 300 - 28592 Orchard Lake Rd. Farmington Hills, MI 48334
Licensee Telephone #:	(586) 493-7300
Administrator:	Luarie Russell
Licensee Designee:	Rita Kumar
Name of Facility:	Riverdale Assisted Living & Memory Care
Facility Address:	44315 N. Gratiot Clinton Twp., MI 48036
Facility Telephone #:	(586) 493-7300
Original Issuance Date:	05/31/2023
License **Status:**	TEMPORARY
Effective Date:	05/31/2023
Expiration Date:	11/29/2023
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
On 10/27, Resident A walked into another resident's room and fell asleep on his bed. The resident came in and beat up Resident A. Resident A suffered a black eye, blood on his shirt, abrasions on his arms, bruising on his chest and a wound on his back.	Yes

III. METHODOLOGY

11/02/2023	Special Investigation Intake 2024A0617005
11/02/2023	Special Investigation Initiated - Telephone TC to LD Ms. Russel
11/02/2023	APS Referral Adult Protective Services (APS) referral received - denied
11/06/2023	Inspection Completed On-site I completed an unannounced onsite investigation at the facility. I interviewed Licensee Designee Ms. Luarie Russell, staff Rebeca Pfropper and Resident B.
11/07/2023	Contact - Document Received Email received from Ms. Russell
12/11/2023	Contact - Telephone call made I interviewed Ms. Vershana Jones.
12/11/2023	Contact - Telephone call made TC to Resident A's son
12/11/2023	Exit Conference I held an exit conference with licensee designee Ms. Russell informing her the findings of the investigation.
12/14/2023	Contact - Telephone call made TC to Resident A son

ALLEGATION:

On 10/27, Resident A walked into another resident's room and fell asleep on his bed. The resident came in and beat up Resident A. Resident A suffered a black eye, blood on his shirt, abrasions on his arms, bruising on his chest and a wound on his back.

INVESTIGATION:

On 11/02/23, a complaint was received regarding the Riverdale Assisted Living and memory care facility. The complaint indicated Resident A is an 85 year old male who has a history of Dementia. Resident A has been living in the Riverdale Memory Care. On 10/27/23, Resident A walked into another resident's room and fell asleep on his bed. The resident came in and beat up Resident A. Staff heard the commotion and took Resident A back to his bed without calling family, hospice, or Resident A's guardian. They did not get him medical treatment either. When Resident A's son/guardian found out what happened the next morning, he went there with the hospice nurse and they found Resident A in bad shape. He had a black eye, blood on his shirt and blankets, abrasions to his arms, bruising on his chest, and a wound on his back. Resident A was transported to McLaren Macomb where he has been admitted. The nursing director, Laurie Russell told the family that they do not call families or hospice when something happens to their residents. The man who beat up Resident A was ranting and raving about how he was going to beat Resident A up again. Resident A's family packed his stuff and left the facility.

On 11/02/23, I conducted a phone interview with licensee designee Laurie Russell. According to Ms. Russell, Resident A went into Resident B's room and got in Resident B's bed. A fight ensued between Resident A and Resident B. According to Ms. Russell, staff Vershawna Jones was the only staff on shift and she was in the living room assisting another resident at the time of the incident. Ms. Russell stated that staff did not make her aware of the incident until 4pm the next day and that is when she contacted the families of the involved residents.

On 11/06/23, I completed an unannounced onsite investigation at the facility. I interviewed licensee designee Ms. Luarie Russell, staff Rebeca Pfropper and Resident B.

During the onsite investigation I reviewed the staff schedule for September, October and November 2023. According to the schedule, staff Vershawna Jones was the only staff member on shift on 10/27/23 from 3pm to 11pm. Per the facility staff schedules, the facility had at least one direct care staff during the day and afternoon shift (waking hours). The facility schedules at least one direct care staff during the evening and midnight shift (normal sleeping hours).

I also reviewed the video footage from the hallway outside of the residents' bedrooms that showed Resident A going inside of Resident B's room at approximately 8:08pm. In the video, you can hear some type of commotion and then several minutes later, Resident B emerges from the bedroom and says, "get the fuck out"! Then Resident B goes to locate staff for assistance.

According to Ms. Pfropper, Resident B was in his bed sleeping and Resident A left his room and went into Resident B's room. Resident A then got into Resident B's bed, which started a fight. Resident B came out and got staff after the fight ended. According to Ms. Pfropper, staff Vershawna Jones was the staff on shift.

According to Ms. Russell, when staff evaluated the residents, both residents appeared to be fine with no cuts or bruises. However, the next morning, Resident A was covered in bruises to his face, arms and neck. Resident A's eye was severally bruised. Ms. Russell provided me with pictures of Resident A's injuries which were consistent with her statement. According to Ms. Russell, the morning after the incident, she had hospice come out and evaluate Resident A and hospice felt he was ok and did not need to go to the hospital. A little while later, Resident A's son arrived at the facility and demanded that Resident A be sent to the hospital. Resident A was sent to the hospital and never returned to the facility as the family withdrew him for the facility.

According to Resident B, Resident A would often open other residents' doors throughout the night. On 10/27/23, Resident B was in his room sleep and Resident A randomly entered Resident B's room and attempted to get in his Resident B's bed. Resident B stated Resident A started grabbing him and he felt as if he needed to defend himself, so he repeatedly punched Resident A until Resident A was no longer a threat. Resident B stated that he then exited his room to locate staff for assistance getting Resident A out of his room. Resident B stated that he was not injured. I did not observe any injuries on Resident B.

On 12/11/23, I interviewed Ms. Vershana Jones. According to Ms. Jones, on 10/27/23, Resident A was having a mental health episode where he walks the facility looking for "Beverly" which is his wife. Resident A went into Resident B's room while he was sleeping and startled him. Resident B started hitting Resident A and when he finished, he came out to the common area and got Ms. Jones and told her what happened. Ms. Jones stated that she was in the common area helping the other seven residents. Resident A and Resident B were the only two residents who were not in her line of sight because they were in their respective rooms. Ms. Jones evaluated both residents and neither had any bruises or cuts. She then contacted her manager to inform her what happened. Ms. Jones thinks there should be two staff members on shift at all times to prevent incidents like this from occurring. The facility does have med technicians, but they work the entire building and only come into the facility to pass medication and leave.

On 12/11/23, I attempted to contact Resident A's son but I was unsuccessful.

On 12/11/23, I held an exit conference with licensee designee Ms. Russell informing her the findings of the investigation. Ms. Russell stated that she would review the report once received.

On 12/14/23, I conducted an interview with Resident A's son. According to Resident A's son, he was not informed of the incident the day it occurred. He was informed the next day by a staff member named Riley. Resident A's son was told that Resident A was attacked by Resident B. Later that day, Resident A's son received a phone call from Ms. Russell telling him that she is conducting an investigation on what happened. Resident A's son went to the facility and observed his father covered in bruises. He called the police and sent his father to the hospital. Resident A's son discharged his father and moved him to another placement. According to Resident A's son, the facility lacks a sufficient amount of staff. There have been many occasions that Resident A's son or other family members have gone to the facility and found the residents alone with no staff present in the facility. According to Resident A's son, there have been other times where maintenance workers or housekeepers are caring for the residents.

APPLICABLE RULE	
R 400.15206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	Based on the information gathered through my interviews and documentation reviews, there is sufficient information to conclude that the facility has violated this rule. Staff Vershawna Jones was the only staff member on shift to provide care for seven residents with dementia and Alzheimer's disabilities. On 10/27/23, Ms. Jones was assisting and caring for five of the seven residents in the common area of the facility, while she believed Resident A and Resident B were in their respective rooms. Ms. Jones was unaware that Resident A had went into Resident B's room, nor was she aware of the altercation that ensued. As a result of the improper supervision with insufficient staff, Resident A was severely injured. According to the schedule, staff Vershawna Jones was the only staff member on shift on 10/27/23 from 3pm to 11pm. According to the schedule, staff Vershawna Jones was the only staff

	member on shift on 10/27/23 from 3pm to 11pm. Per the facility staff schedules, the facility had one direct care staff during the day and afternoon shift (waking hours). The facility schedules one direct care staff during the evening and midnight shift (normal sleeping hours). I also reviewed the video footage from the hallway outside of the residents' bedrooms that showed Resident A going inside of Resident B's room at approximately 8:08pm. In the video, you hear some type of commotion and then several minutes later, Resident B emerges from the bedroom and says, "get the fuck out"! Resident B then goes to locate staff for assistance. During interview, Ms. Jones believes it would be in the best interest of the residents if there were always at least two staff on shift. It would provide additional supervision while staff assists resident with their care needs.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Based on the information gathered through my interviews and documentation reviews, there is sufficient information to conclude that the facility has violated this rule. I reviewed the video footage from the hallway outside of the residents' bedrooms that showed Resident A going inside of Resident B's room at approximately 8:08pm. In the video, you can hear some type of commotion and then several minutes later, Resident B emerges from the bedroom and says, "get the fuck out"! Then Resident B goes to locate staff for assistance. As a result of the improper supervision, Resident A was severely injured. According to Ms. Russell and Ms. Jones, when Ms. Jones evaluated the residents, both residents appeared to be fine with no cuts or bruises. However, the next morning, Resident A was covered in bruises to his face, arms and neck. Resident A's eye was severally bruised. Ms. Russell provided me with pictures of Resident A's injuries which were consistent with her statement.

CONCLUSION:	**VIOLATION ESTABLISHED**

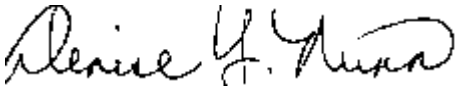
IV. RECOMMENDATION

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

12/11/23

Eric Johnson Date
Licensing Consultant

Approved By:



12/19/2023

Denise Y. Nunn Date
Area Manager