GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 24th, 2024

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

RE: License #: AH410393434
Investigation #: 2024A1021043
Rivertown Ridge

Dear Eric 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 #:	2024A1021043
Complaint Receipt Date:	03/12/2024
Investigation Initiation Date:	03/13/2024
Report Due Date:	05/11/2024
Licensee Name:	Traditions at Rivertown Park, LLC
Licensee Address:	3330 Grand Ridge Drive NE Grand Rapids, MI 49525
Licensee Telephone #:	(616) 580-1098
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 did not receive prescribed medication.	Yes
Additional Findings	Yes

III. METHODOLOGY

03/12/2024	Special Investigation Intake 2024A1021043
03/13/2024	Special Investigation Initiated - Letter email sent to complainant for additional information
03/14/2024	Inspection Completed On-site
03/18/2024	Contact-Telephone call made Interviewed HomeTown Pharmacy
03/18/2024	Contact-Telephone call made Interviewed Mark Bates, MD office
04/24/2024	Exit Conference

ALLEGATION:

Resident A did not receive prescribed medication.

INVESTIGATION:

On 03/12/2024, the licensing department received a complaint with allegations Resident A did not receive prescribed medications.

On 03/13/2024, I contacted the complainant and received the following information:

March 1, 2024: Resident A did not receive Olanzapine 2.5 mg. The prescription was on profile but not filled.
March 4, 2025: Resident A did not receive Olanzapine 2.5 mg even though medication was at the facility.
March 7, 2025: Resident A did not receive Olanzapine 7.5mg

On 03/14/2024, I interviewed staff person 1 (SP1) at the facility. SP1 reported Resident A resided at the facility 02/17/2024 to 03/13/2024. SP1 reported Resident

A had many medications changes due to behavior issues. SP1 reported Resident A admitted to the facility from Pine Rest. SP1 reported Resident A admitted to the facility with no medications from home. SP1 reported the facility uses HomeTown Pharmacy for prescriptions. SP1 reported if a new prescription is written early in the day the prescription should be delivered later that day or the next day. SP1 reported no knowledge of issues with Resident A's medications or incorrect prescriptions sent.

On 03/14/2024, I interviewed SP2. SP2 reported Resident A had many different medication bottles. SP2 reported Resident A ran out of medications and the facility was using what he brought from home.

On 03/21/2024, I interviewed SP3 by telephone. SP3 reported Resident A had many medication changes and it was difficult to ensure all medication changes were reflected in the medication administration record (MAR). SP3 reported HomeTown Pharmacy never contacted the facility to let them know there was an issue with the prescription. SP3 reported when a medication is not administered, the facility is to contact the family. SP3 reported the facility will try to contact the physician but it is not required. SP3 reported the facility has constant communication with HomeTown Pharmacy.

On 03/18/2024, I interviewed HomeTown Pharmacy worker Rebecca Doran by telephone. Ms. Doran reported on 02/23/2024, the pharmacy received a prescription for Olanzapine 2.5mg. Ms. Doran reported the e-prescription was written with Rivertown Ridge and prescribed by Mark Bates, MD. Ms. Doran reported the facility and pharmacy policy is if a prescription is written with Rivertown Ridge name, the prescriber must be an approved prescriber. Ms. Doran reported Mark Bates, MD is not an approved prescriber through Rivertown Ridge and therefore the prescription was not filled because it had Rivertown Ridge on it and not the prescriber office information. Ms. Doran reported the facility is aware of this policy and was not informed of the inability to fill the prescription. Ms. Doran reported on 03/01/2024, the pharmacy received a verbal order from prescribing doctor for the medication. Ms. Doran reported the medication was sent out that day and the quantity was at least 15 tablets. Ms. Doran reported on 02/26/2024, the pharmacy received a prescription for Olanzapine 7.5mg and this e-script was valid as it was written from Swapril Rath from Older Adult Unit. Ms. Doran reported the pharmacy delivered 30 tablets.

I reviewed Resident A's medication administration record (MAR). The MAR revealed Resident A was prescribed Olanzapine 2.5mg tablet with a start date of 02/23 and a discharge date of 03/06. Resident A did not receive this medication on 02/23-03/01 and on 03/07. Resident A was prescribed Olanzapine tablet 7.5mg with a start date of 02/17 and a discharge date of 03/10. Resident A did not receive this medication on 02/18, 02/20, 02/23, 02/24, 03/01, 03/05, 03/06. The reason for the missed medications was that the medication was not delivered from pharmacy.

I reviewed policy for medication administration. The policy was written,

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“If a medication is not delivered to from the pharmacy. The staff are instructed to call the pharmacy to trace the medication down. Staff are instructed to document that the medication is not available until medication is provided. Notify the director and the Care Coordinator.

Family, provider and /or agency are notified and instructed to obtain the medication to enable us to administer. It is explained to family upon admission of the administration of medication process, and how failure to obtain proper written prescriptions is a delay in care.

IF the medication is not delivered because there is not a proper script. The pharmacy is supposed to request proper documentation. The nurse, care coordinator, or med tech is to follow up.”

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to labeling instructions or orders by the prescribing licensed health care professional.
ANALYSIS:	Interviews conducted and review of documentation revealed Resident A was prescribed 2.5mg of Olanzapine. The pharmacy received a valid prescription on 03/01 and delivered 15 tablets. However, Resident A did not receive this medication on 03/07. In addition, Resident A was prescribed Olanzapine 7.5mg. The pharmacy received a valid prescription on 02/16/2024 and 30 tablets was delivered. However, Resident A did not receive this medication on 02/18, 02/20, 02/23, 02/24, 03/01, 03/05, 03/06.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 325.1921	**Admission and retention of residents.**
	(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
	(p) "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:	Review of facility policy revealed the medication technician is to inform the management team of issues with medications not delivered. The facility was unable to provide evidence that management was made aware of the delivery issues of the Olanzapine medication. The facility failed an organized program of protection for Resident A by not following their policy to ensure medications were obtained.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 3/18/2024, I interviewed Mark Bates office. The office reported they were not made aware of the missed medications.

Interviews conducted with staff members at the facility revealed discrepancies on if the provider is contacted or if the family is contacted when residents missed medications.

APPLICABLE RULE	
	Resident medications.
	(3) Staff who supervise the administration of medication for residents who do not self-administer shall comply with all of the following: **(c) Contact the appropriate licensed health care professional when the prescribed medication has not been administered in accordance with the label instruction, an order from a health care professional, medication log, or a service plan.**

ANALYSIS:	Interviews conducted revealed the facility did not appropriately contact the licensed health care professional when Resident A did not receive the prescribed medication.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Kimberly Horst

03/26/2024

Kimberly Horst — Date
Licensing Staff

Approved By:

Andrea L. Moore

04/23/2024

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