GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 30, 2024

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

RE: License #: AL500402308
Investigation #: 2024A0617027
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.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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

I. IDENTIFYING INFORMATION

License #:	AL500402308
Investigation #:	2024A0617027
Complaint Receipt Date:	07/15/2024
Investigation Initiation Date:	07/15/2024
Report Due Date:	09/13/2024
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:	Rita Kumar
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:**	REGULAR
Effective Date:	11/30/2023
Expiration Date:	11/29/2025
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was dead in his room for more than six hours before anything was done.	Yes

III. METHODOLOGY

07/15/2024	Special Investigation Intake 2024A0617027
07/15/2024	APS Referral Adult Protective Services referral rec- Assigned worker Heather Horan
07/15/2024	Special Investigation Initiated – Telephone TC with Ms. Horan
07/15/2024	Contact - Telephone call made TC to MedStar medical services
07/15/2024	Contact - Telephone call made TC to Clinton Township Fire Department
07/15/2024	Contact - Telephone call made TC to Clinton Township Police Department
07/15/2024	Contact - Telephone call made TC with Ms. Patricia Conner
07/16/2024	Inspection Completed On-site I conducted an unannounced investigation of the Riverdale Assisted Living & Memory Care facility. I interviewed staff Essie Shaw, Aliyyah Wells, Bionca Thorman, facility head nurse Patricia Conner, executive director Brian Radyko, and licensee designee Rita Kumar. I attempted to interview several residents, but they were unable to answer questions due to cognitive disabilities.
07/16/2024	Contact - Document Received Email received from Mr. Radyko

07/16/2024	Contact - Telephone call made TC to Mr. Marlon Williams
08/06/2024	Contact - Telephone call made TC to Mr. Marlon Williams
08/06/2024	Contact - Telephone call made I interviewed staff Sheritta Smith
08/06/2024	Contact - Telephone call made I interviewed staff Meranda Parker
08/06/2024	Contact - Telephone call made I interviewed staff Taylor Burnett
08/06/2024	Contact - Telephone call made I interviewed Resident A's daughter
08/06/2024	Contact - Document Received I received and reviewed a copy of Resident A's death certificate
08/22/2024	Contact - Telephone call made TC to Dr. Mary Pietrangelo medical examiner
08/22/2024	Contact - Document Sent Email sent to Dr. Mary Pietrangelo medical examiner
08/23/2024	Exit Conference I conducted an exit conference with licensee designee Rita Kumar to discuss the findings of this report.
08/27/2024	Contact – Document Received Email received from Dr. Mary Pietrangelo Macomb County Chief medical examiner
08/29/2024	Contact- Telephone call received TC with Ms. Kumar

ALLEGATION:

Resident A was dead in his room for more than six hours before anything was done.

INVESTIGATION:

On 07/15/24, I received a complaint on the Riverdale Assisted Living & Memory Care facility. The complaint stated that on Saturday, July 6, 2024, Resident A was found dead in his room, which is not uncommon for the facility, but the resident was there for more than six hours, and nobody checked on him. The EMS workers said that Resident A was already in rigor mortis status. The med tech stated that she passed medication to Resident A on morning shift, but she couldn't have because he was already deceased. The executive director is hiding this and pushing it under the rug, so the family won't find out. Med Star was the ambulance that came up here and the fire department and police were also present, so you can check with all three. The guy had never been checked all morning and that is very concerning to me.

On 07/16/24, I conducted an unannounced investigation of the Riverdale Assisted Living & Memory Care facility. I interviewed staff Essie Shaw, Aliyyah Wells, Bionca Thorman, facility head nurse Patricia Conner, executive director Brian Radyko, and licensee designee Rita Kumar. I attempted to interview several residents, but they were unable to answer questions due to cognitive disabilities.

When I arrived at the facility, Ms. Shaw was the only employee in the facility. Ms. Wells who was the med tech on shift was outside tending to her vehicle. Therefore, the facility did not have a med tech available to the residents as Ms. Shaw is a direct care worker and not trained to administer medications. According to Ms. Shaw, all of the employee records are located in the facility office, but the office was locked, and she did not have a key to access the office. Ms. Shaw could not provide a resident registry and was not fully aware of what residents were in the facility nor how many. I went to all the rooms and verified that there were six residents in the facility at the time of the investigation. Ms. Shaw stated that Resident A passed away on 07/07/24 but she was not working that day and could not provide any additional information.

Head nurse Ms. Patricia Conner came to the facility to assist with the investigation and stated that the resident files were located in her office because she pulled them to work on them and bring them into compliance. We went to her office to review the files and Resident A's file was blank with no required AFC forms completed. Ms. Conner was able to provide me with an incident report regarding Resident A. According to the incident report, on 7/7/24, staff went into Resident A's room to help change the resident. Staff realized that Resident A was not responding. The report stated that, "I can tell by the color of his skin, he was deceased. I called my supervisor to let her know". The report also stated, "I saw resident unresponsive, skin pale no response". The incident report does not indicate who wrote the report but according to Ms. Conner, the report was completed by Ms. Wells.

Ms. Conner provided me with staff schedules for July 6th and 7th 2024. According to the staff schedule, staff Marlon Williams worked the midnight shift on 7/6/24 from 11pm to 7am the next day. Mr. Williams is a contracted employee through a third-party agency.

On 07/07/24, Aliyyah Wells was the med tech from 7am to 3pm and Meranda Parker was the direct care worker from 7am to 3pm.

Ms. Conner provided me with a copy of the medication log for Resident A for the month of July 2024. According to the medication log, the following medication errors for Resident A were found:

-Pantoprazole Tab 40MG- Was not given on 7/6 (5pm)- Log states that the medication was not available but the 8am dose on 7/6 was given/initialed.
-Pantoprazole Tab 40MG- The 5pm dosage of the medication was not given from 7/1-7/6
-Pantoprazole Tab 40MG- the 8am dosage was not given on 7/2 and 7/5; the medication log states that the medication was not available however, the 8am dosage was given/initialed on 7/1, 7/3, 7/4, and 7/6
-Sertraline tab 100MG -was not given from 7/1-7/7
-Sertraline Tab 50MG -was not given on 7/6 and 7/7
-Vitamin D (3) 5,000 units caps- was not given from 7/4-7/7

*According to the medication log, Resident A received the following medication on 07/07/24 (day of death):

-Culturelle CAP- given at 8am by staff AW (Aliyyah Wells)
-Divalproex tab 125mg - given at 8am by staff AW (Aliyyah Wells)
-Effer-k tab 20MEQ - given at 8am by staff AW (Aliyyah Wells)
-Folic Acid tab 400mg - given at 8am by staff AW (Aliyyah Wells)
-Memantine tab HCL 5mg - given at 8am by staff AW (Aliyyah Wells)
-Rivastigmine cap 6mg - given at 8am by staff AW (Aliyyah Wells)
-Telmisartan tab 20mg - given at 8am by staff AW (Aliyyah Wells)
-Vitamin B-12 1,000 MCG tab - given at 8am by staff AW (Aliyyah Wells)

According to Ms. Wells, she worked as the med tech on 7/7/24 at Riverdale but the affiliated AFC Sunnydale located down the hall was without a med tech so she had to cover both facilities at the same time. Ms. Wells stated that she passed the medications for Riverdale residents at about 8am, however, Resident A did not get his 8am medication. Ms. Wells stated that Resident A usually tends to refuse his 8 am medications because he is not a morning person. Therefore, Ms. Wells will usually wait until 1pm to give him his 8am medications. Ms. Wells stated that she did not attempt to pass Resident A's 8am medications on 7/7 because she was super busy going back and forward between facilities. Ms. Wells stated that she did not check on Resident A until 1pm and when she went into his room, she found him deceased. Ms. Wells stated that Resident A's door was open, and she thought he was just sleeping. When Ms. Wells found Resident A deceased, she immediately contacted her manager and her manager called EMS and the family. Ms. Wells stated that she left the facility around 3pm but came back around 5pm to give a statement to the police.

I showed Ms. Wells Resident A's medication log and asked her if she signed for his 8am medications being administered on 7/7/24 and she replied "yes". Ms. Wells stated that she always signs off on the medication being administered to Resident A prior to actually passing them due to time constraints.

I reviewed the staff schedule for Sunnydale since (Aliyyah Wells said that she had to cover for both facilities on 7/7. So, I verified who was supposed to be working at Sunnydale and I interviewed her to see if she in fact worked that day or not) and on 7/7 from 7am to 3pm Ms. Bionca Thurman was scheduled to work. During the onsite investigation, I interviewed Ms. Thurman. According to Ms. Thurman, she did not work on 7/7/24 as she was on vacation at that time.

According to Mr. Radyko, Resident A passed away and the facility followed the proper protocols. Mr. Radyko stated that some of the employees are brought in by a third party agency called Kare and the facility is not in possession of those staff files. Mr. Radyko stated that he would have to contact Kare to retrieve staff files. Mr. Radyko stated that although it is alleged that Resident A was in the rigor mortis state when discovered, that is not an indication of neglect by staff because there is no set amount of time for the rigor mortis process to take place. Mr. Radyko provided me with a copy of the resident registry and the registry was inaccurate as the names on the registry did not match the actual residents in the facility.

On 07/16/24, I received and reviewed staff files for Taylor Burnett, Shailynn Prince, Dahila Patterson, and Marlon Williams. These staff members are staff from a third-party agency called Kare. Each of the staff members were found on the staff schedule for Riverdale Assisted Living. According to the files staff Taylor Burnett, Shailynn Prince, Marlon Williams and Dahila Patterson were missing the following required AFC documents:

-Verification of experience, education, and training.
-Verification of reference checks.
-Beginning and ending dates of employment.
-Medical information, as required.
-Required verification of the receipt of personnel policies and job descriptions.
-Mr. Marlon William's file was also missing a completed background check.

On 08/06/24, I interviewed staff Sheritta Smith. According to Ms. Smith, she did not work on 07/07/24, despite the staff schedule indicating that she worked on 7/7/24 from 3pm to 11pm. Ms. Smith stated that the schedules are not accurate most of the time.

On 08/06/24, I interviewed staff Meranda Parker. Ms. Parker stated that she worked the morning of 7/7/24 from 7am to 3pm. Ms. Parker stated that she was working with med tech Aliyyah Wells. According to Ms. Parker, it was a hectic morning with the residents. There was a fire alarm during the midnight shift the night before and residents were restless. Ms. Parker stated that Ms. Wells was passing medications while she set the residents up for breakfast. Resident A was in his room assumed sleeping because the

midnight staff told Ms. Parker that Resident A was up most of the night screaming and agitated and she should let him sleep. Ms. Parker stated that she peaked into Resident A's room around 7am but never went into his room. Resident A's door was open, and she was listening for if he needed anything. Ms. Parker stated that she went into Resident A's room around 2pm to check on him because he had not been up all day. When Ms. Parker went into Resident A's room, she immediately could tell he was deceased.

On 08/06/24, I interviewed staff Taylor Burnett. According to Ms. Burnett, she was working on the third floor of the building and not in the Riverdale facility on 07/06/24 and 07/07/24. Around 11:30pm on 07/06/24 staff Marlon Williams who was working alone at Riverdale, came to the third floor and told Ms. Burnett that he will not be back in the building until around 5:30am. Ms. Burnett stated that the residents were left without staff until around 4:30am when the fire alarm in the building went off. Staff couldn't find Mr. Williams until about 5am. Ms. Burnett stated that her coworkers told her that Resident A's body and room was ice cold and the temperature in his room was below 60 degrees. Ms. Burnett stated that her coworker also told her that Resident A was found in soiled briefs.

On 08/06/24, I interviewed Resident A's daughter. According to Resident A's daughter, the situation surrounding her father's death was very "shady". Resident A was seen by a doctor 5 days prior and his vitals were strong and there were no concerns regarding his health. Resident A's daughter stated that the facility had many issues with staff and the quality of care that was provided to the residents. Resident A's daughter stated that Resident A's death certificate's reason of death was natural causes, but no autopsy was completed.

On 08/06/24, I received and reviewed a copy of Resident A's death certificate. According to the death certificate, Resident A was pronounced dead at 3:31pm on 7/7/24 and his death was natural. No autopsy was performed.

I made multiple attempts to contact Mr. Williams but were unsuccessful.

On 08/23/24, I conducted an exit conference with licensee designee Rita Kumar to discuss the findings of this report. Ms. Kumar stated that she has taken a more hands on approach and is actively working to get the facility into compliance.

On 08/27/24, I received an email from Dr. Mary Pietrangelo Macomb County Chief Medical Examiner. According to Dr. Pietrangelo, Resident A was last known alive on 7/7/24 at 08:00 when he refused his medications from staff. He was found unresponsive at 14:00 by his caregiver Aliyyah Wells. He was pronounced at 15:31 after police and EMS arrived. The staff delayed calling 911 because they called the supervisor first. His face sheet indicated he was a full code, so it's not clear to Dr. Pietrangelo why there was a delay in calling 911, or if his code status had changed. The county investigator did go to the facility. Dr. Shah and Dr. Gietzen refused to sign Resident A's death certificate. The physician assistant is unable to sign in Michigan. Dr. Pietrangelo

reviewed Riverdale's face sheet which listed Resident A's medications and code status and some other demographic info. The face sheet indicates that the staff doctor was Dr. Shah and that she was the primary physician. From the face sheet it appears that Resident A was admitted to Riverdale on 3/2/24. Dr. Pietrangelo also reviewed the records of physician assistant Bennett, who was under the supervision of Dr. Gietzen. Resident A had been seen since 2020 at that office, the last time being 2/15/24, probably before he entered Riverdale.

On 08/29/24, I spoke with Ms. Rita Kumar. According to Ms. Kumar, she has personally been to the facility ensuring that the necessary corrections are being made to bring the facility into compliance.

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:	On 07/07/24, Resident A's personal needs were not met by the facility. Resident A was not checked on nor was his medications administered on 07/07/24. Also, Resident A's briefs were not changed, and he was not fed. According to Dr. Pietrangelo, Resident A was last known alive on 7/7/24 at 08:00 when he refused his medications from staff. He was found unresponsive at 14:00 by his caregiver Aliyyah Wells. However, Ms. Wells told me that she never passed Resident A's meds, nor did she enter his room. The medication logs indicated that Ms. Wells documented that she passed all of Resident A's 8am medications on time.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference SIR #2024A0617005 and CAP dated 1/31/24**

APPLICABLE RULE	
R 400.15310	**Resident Health Care**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately

ANALYSIS:	According to Dr. Pietrangelo, Resident A was pronounced dead at 15:31 after police and EMS arrived. The staff delayed calling 911 because they called the supervisor first. His face sheet indicated he was a full code, so it's not clear to Dr. Pietrangelo why there was a delay in calling 911.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
MCL 400.734b	**Employing or contracting with certain individuals providing direct services to residents; prohibitions; criminal history check; exemptions; written consent and identification; conditional employment; use of criminal history record information; disclosure; determination of existence of national criminal history; failure to conduct criminal history check; automated fingerprint identification system database; electronic web-based system; costs; definitions.**
	(2) Except as otherwise provided in this subsection or subsection (6), an adult foster care facility shall not employ or independently contract with an individual who has direct access to residents until the adult foster care facility or staffing agency has conducted a criminal history check in compliance with this section or has received criminal history record information in compliance with subsections (3) and (11). This subsection and subsection (1) do not apply to an individual who is employed by or under contract to an adult foster care facility before April 1, 2006. On or before April 1, 2011, an individual who is exempt under this subsection and who has not been the subject of a criminal history check conducted in compliance with this section shall provide the department of state police a set of fingerprints and the department of state police shall input those fingerprints into the automated fingerprint identification system database established under subsection (14). An individual who is exempt under this subsection is not limited to working within the adult foster care facility with which he or she is employed by or under independent contract with on April 1, 2006 but may transfer to another adult foster care facility, mental health facility, or covered health facility. If an individual who is exempt under this subsection is subsequently convicted of a crime or offense described under subsection (1)(a) to (g) or found to be the subject of a substantiated finding described under subsection (1)(i) or an order or disposition described under

	subsection (1)(h), or is found to have been convicted of a relevant crime described under 42 USC 1320a-7(a), he or she is no longer exempt and shall be terminated from employment or denied employment.
ANALYSIS:	On 07/16/24, I received and reviewed staff file for Marlon Williams and Mr. Marlon William's file was missing a completed background check. Mr. Williams was listed on the staff schedule working on 07/06/24 from 11pm to 7am.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15201	**Qualifications of administrator, direct care staff, licensee, and members of household; provision of names of employee, volunteer, or member of household on parole or probation or convicted of felony; food service staff.**
	(9) A licensee and the administrator shall possess all of the following qualifications: **(a) Be suitable to meet the physical, emotional, social, and intellectual needs of each resident.**
ANALYSIS:	Over the last several months, the Riverdale facility has had a renewal inspection and three special investigations which all concluded with severe violations. Ms. Kumar has failed to bring the facility into compliance with AFC rules and regulations. I have provided Ms. Kumar with technical assistance on numerous occasions however, she has remained hands off from the facility. Ms. Kumar has hired multiple people to run the day-to-day operations of the facility and has not taken responsibility to rectify the violations; the residents continue to suffer as a result. Ms. Kumar has failed to demonstrate that she is suitable to meet the physical, emotional, and intellectual needs of each resident.
CONCLUSION:	VIOLATION ESTABLISHED

APPLICABLE RULE	
R 400.15204	**Direct care staff; qualifications and training.**
	(3) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be competent before performing assigned tasks, which shall include being competent in all of the following areas:

	(a) Reporting requirements. **(b) First aid.** **(c) Cardiopulmonary resuscitation.** **(d) Personal care, supervision, and protection.** **(e) Resident rights.** **(f) Safety and fire prevention.** **(g) Prevention and containment of communicable diseases.**
ANALYSIS:	On 07/16/24, I received and reviewed staff files for Taylor Burnett, Shailynn Prince, Dahila Patterson, and Marlon Williams. These staff members are staff from a third-party agency called Kare. Each of the staff members were found on the staff schedule for Riverdale Assisted Living. According to the files, staff Taylor Burnett, Shailynn Prince, Marlon Williams and Dahila Patterson were missing all required AFC trainings.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference SIR #2024A0617018 and CAP dated 7/26/24**

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, the facility does not schedule sufficient staff to provide supervision, personal care and protection of residents at all times. According to the schedules from June 2024 and July 2024, the facility does not schedule med techs during the night shift. Also, there were several days where there were no staff scheduled for the midnight shift. There were several days during June and July 2024 that the facility scheduled one med tech for both Riverdale and their affiliated AFC facility Sunnydale which is next door. According to Ms. Wells, she has had to go between the two facilities to pass meds because of lack of staff. According to Ms. Wells, she worked as the med tech on 7/7/24 at Riverdale but the affiliated AFC Sunnydale located down the hall was without a med tech, so she had to cover both facilities at the same time. Ms. Wells stated that she did not attempt to pass Resident A's 8am medications on 7/7 because she was super busy going back and forward between facilities. Ms. Wells stated that she did not check on Resident A until 1pm and when she went into his room, she found him deceased.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference SIR #2024A0617005 and CAP dated 1/31/24**

APPLICABLE RULE	
R 400.15208	**Direct care staff and employee records.**
	(1) A licensee shall maintain a record for each employee. The record shall contain all of the following employee information: **(e) Verification of experience, education, and training.** **(f) Verification of reference checks.** **(g) Beginning and ending dates of employment.** **(h) Medical information, as required.** **(i) Required verification of the receipt of personnel policies and job descriptions.**

ANALYSIS:	On 07/16/24, I received and reviewed staff files for Taylor Burnett, Shailynn Prince, Dahila Patterson, and Marlon Williams. These staff members are staff from a third-party agency called Kare. Each of the staff members were found on the staff schedule for Riverdale Assisted Living. According to the files staff Taylor Burnett, Shailynn Prince, Marlon Williams and Dahila Patterson were missing the following required AFC documents: -Verification of experience, education, and training. -Verification of reference checks. -Beginning and ending dates of employment. -Medical information, as required. -Required verification of the receipt of personnel policies and job descriptions. -Mr. Marlon William's file was also missing a completed background check.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference SIR #2024A0617018 and CAP dated 7/26/24**

APPLICABLE RULE	
R 400.15208	**Direct care staff and employee records.**
	(3) A licensee shall maintain a daily schedule of advance work assignments, which shall be kept for 90 days. The schedule shall include all of the following information: **(a) Names of all staff on duty and those volunteers who are under the direction of the licensee.** **(b) Job titles.** **(c) Hours or shifts worked.** **(d) Date of schedule.** **(e) Any scheduling changes.**

ANALYSIS:	According to Mr. Radyko, the staff are expected to initial next to their name on the schedule to indicate that they worked. However, there are times when staff forget to initial. I reviewed the staff schedule for June and July 2024 and the schedule was missing a multitude of initials, therefore making it impossible to verify who actually worked. On 08/06/24, I interviewed staff Sheritta Smith. According to Ms. Smith, she did not work on 07/07/24, despite the staff schedule indicating that she worked on 7/7/24 from 3pm to 11pm. Ms. Smith stated that the schedules are not accurate most of the time.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15210	**Resident register.**
	A licensee shall maintain a chronological register of residents who are admitted to the home. The register shall include all of the following information for each resident: **(a) Date of admission.** **(b) Date of discharge.** **(c) Place and address to which the resident moved, if known.**
ANALYSIS:	During the onsite investigation, the facility was unable to provide an accurate resident register.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	During the onsite investigation, Ms. Conner provided me with a copy of the Medication log for Resident A for the month of July 2024. According to the Medication log, the following medication errors for Resident A were found: -Pantoprazole Tab 40MG- Was not given on 7/6 (5pm)- Log states that the medication was not available but the 8am dose on 7/6 was given/initialed. -Pantoprazole Tab 40MG- The 5pm dosage of the medication was not given from 7/1-7/6

	-Pantoprazole Tab 40MG- the 8am dosage was not given on 7/2 and 7/5; the medication log states that the medication was not available however, the 8am dosage was given/initialed on 7/1, 7/3, 7/4, and 7/6 -Sertraline tab 100MG -was not given from 7/1-7/7 -Sertraline Tab 50MG -was not given on 7/6 and 7/7 -Vitamin D (3) 5,000 units caps- was not given from 7/4-7/7
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(b) Complete an individual medication log that contains all of the following information:** **(i) The medication.** **(ii) The dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.** **(e) Not adjust or modify a resident's prescription medication without instructions from a physician or a pharmacist who has knowledge of the medical needs of the resident. A licensee shall record, in writing, any instructions regarding a resident's prescription medication.** **(f) Contact the appropriate health care professional if a medication error occurs or when a resident refuse prescribed medication or procedures and follow and record the instructions given.**
ANALYSIS:	During the onsite investigation, Ms. Wells stated that she passed the medications for Riverdale residents at about 8am, however, Resident A did not get his 8am medication. Ms. Wells stated that Resident A usually tends to refuse his 8 am medications because he is not a morning person. Therefore, Ms. Wells will usually wait until 1pm to give him his 8am medications. Ms. Wells did not get permission from a medical professional to adjust the time of Resident A's medications.

	Also, the medication logs did not indicate that Resident A refused any medications despite Ms. Wells stating that he usually refuses his 8am meds. According to the medication log, Resident A received the following medication on 07/07/24(day of death): - Culturelle CAP- given at 8am by staff AW (Aliyyah Wells) -Divalproex tab 125mg - given at 8am by staff AW (Aliyyah Wells) -Effer-k tab 20MEQ - given at 8am by staff AW (Aliyyah Wells) -Folic Acid tab 400mg - given at 8am by staff AW (Aliyyah Wells) -Memantine tab HCL 5mg - given at 8am by staff AW (Aliyyah Wells) -Rivastigmine cap 6mg - given at 8am by staff AW (Aliyyah Wells) -Telmisartan tab 20mg - given at 8am by staff AW (Aliyyah Wells) -Vitamin B-12 1,000 MCG tab - given at 8am by staff AW (Aliyyah Wells) Ms. Wells stated that she did not attempt to pass Resident A's 8am medications on 7/7 because she was super busy going back and forward between facilities. Ms. Wells stated that she did not check on Resident A until 1pm and when she went into his room, she found him deceased. I showed Ms. Wells Resident A's medication log and asked her if she signed for his 8am medications being administered on 7/7/24 and she replied yes. Ms. Wells stated that she always signs off on the medication being administered to Resident A prior to actually passing them due to time constraints. Ms. Wells admitted to falsifying medical records by indicating that she administered medications that she did not actually administer. According to Dr. Pietrangelo, Resident A was last known alive on 7/7/24 at 08:00 when he refused his medications from staff. He was found unresponsive at 14:00 by his caregiver Aliyyah Wells. However, Ms. Wells told me that she never passed Resident A's meds, nor did she enter his room. The medication logs indicated that Ms. Wells documented that she passed all of Resident A's 8am medications on time. According to Dr. Pietrangelo, Resident A was pronounced dead at 15:31 after police and EMS arrived.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED**

	Reference Renewal Inspection dated 12/19/23 and CAP dated 01/26/24 and SIR # 2024A0617018 and CAP dated 7/26/24

APPLICABLE RULE	
R 400.15316	**Resident records.**
	(1) A licensee shall complete, and maintain in the home, a separate record for each resident and shall provide record information as required by the department. A resident record shall include, at a minimum, all of the following information: **(a) Identifying information, including, at a minimum, all of the following:** **(i) Name.** **(ii) Social security number, date of birth, case number, and marital status.** **(iii) Former address.** **(iv) Name, address, and telephone number of** the next of kin or the designated representative. **(v) Name, address, and telephone number of the person and agency responsible for the resident's placement in the home.** **(vi) Name, address, and telephone number of the preferred physician and hospital.** **(vii) Medical insurance.** **(viii) Funeral provisions and preferences.** **(ix) Resident's religious preference information.** **(b) Date of admission.** **(c) Date of discharge and the place to which the resident was discharged.** **(d) Health care information, including all of the following:** **(i) Health care appraisals.** **(ii) Medication logs.** **(iii) Statements and instructions for supervising prescribed medication, including dietary supplements and individual special medical procedures.** **(iv) A record of physician contacts.** **(v) Instructions for emergency care and advanced medical directives.** **(e) Resident care agreement.** **(f) Assessment plan.**

	(g) Weight record. **(h) Incident reports and accident records.** **(i) Resident funds and valuables record and resident refund agreement.** **(j) Resident grievances and complaints.** **(2) Resident records shall be kept on file in the home for 2 years after the date of a resident's discharge from a home.**
ANALYSIS:	During the onsite investigation, head nurse Ms. Patricia Conner came to the facility to assist with the investigation and stated that the resident files were located in her office because she pulled them to work on them and bring them into compliance. We went to her office to review the files and Resident A's and several other resident files were blank with no required AFC forms completed.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference SIR # 2024A0617018 and CAP dated 7/26/24**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan I recommend a six-month 1st provisional license.

08/23/24

Eric Johnson Date
Licensing Consultant

Approved By:

08/30/2024

Denise Y. Nunn Date
Area Manager