



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
DIRECTOR

April 17, 2026

Carol Delraso  
Riley's Grove Assisted Living  
9481 Pentatech  
Zeeland, MI 49464

RE: License #: AH700396224  
Investigation #: 2026A1021035  
Riley's Grove Assisted Living

Dear Carol Delraso:

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) 335-5985.

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**

<b>License #:</b>	AH700396224
<b>Investigation #:</b>	2026A1021035
<b>Complaint Receipt Date:</b>	03/31/2026
<b>Investigation Initiation Date:</b>	04/01/2026
<b>Report Due Date:</b>	05/30/2026
<b>Licensee Name:</b>	Riley's Grove Assisted Living, LLC
<b>Licensee Address:</b>	Ste 200, 3196 Kraft Ave. SE Grand Rapids, MI 49512
<b>Licensee Telephone #:</b>	Unknown
<b>Administrator/ Authorized Representative:</b>	Carol Delraso
<b>Name of Facility:</b>	Riley's Grove Assisted Living
<b>Facility Address:</b>	9481 Pentatech, Zeeland, MI 49464
<b>Facility Telephone #:</b>	(616) 748-0565
<b>Original Issuance Date:</b>	11/16/2020
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	08/01/2025
<b>Expiration Date:</b>	07/31/2026
<b>Capacity:</b>	70
<b>Program Type:</b>	AGED ALZHEIMERS

## II. ALLEGATION(S)

	<b>Violation Established?</b>
Call lights are not answered.	Yes
Residents are abused and neglected.	No
Facility has insufficient staff.	No
Medications are left out and medication carts are unlocked.	Yes
Additional Findings	Yes

## III. METHODOLOGY

03/31/2026	Special Investigation Intake 2026A1021035
04/01/2026	Special Investigation Initiated - Letter email sent to complainant
04/08/2026	Inspection Completed On-site
04/15/2026	Contact-Telephone call made Interviewed SP1
04/17/2026	Exit Conference

The complainant alleged that residents are left soiled overnight. This allegation was investigated under investigation report 2026A1028025.

### **ALLEGATION:**

**Call lights are not answered.**

### **INVESTIGATION:**

On 03/31/2026, the licensing department received a complaint with allegations that call lights are not answered.

On 04/08/2026, I interviewed Resident A at the facility. Resident A reported it can take 10-15 minutes for staff assistance. Resident A reported it can be difficult to find staff at the facility.

On 04/08/2026, I interviewed staff person 2 (SP2) at the facility. SP2 reported that call lights are expected to be answered within 10 minutes. SP2 reported no knowledge of complaints on call lights not being answered.

I reviewed the facility call light response time for 04/01/2026-04/08/2026. The document revealed the average call light response time was 15 minutes. I reviewed the facility call light response time for 03/25/2026-04/08/2026 and the average response time was 19 minutes.

<b>APPLICABLE RULE</b>	
<b>R 325.1921</b>	<b>Governing bodies, administrators, and supervisors.</b>
	<b>(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.</b>
<b>For Reference: R 325.1901</b>	<b>Definitions.</b>
	<b>(d) "Assistance" means help provided by a home or an agent or employee of a home to a resident who requires help with activities of daily living.</b>
<b>ANALYSIS:</b>	Interviews with residents and review of call light response times revealed on average residents wait between 17-19 minutes. This practice results in residents not receiving the assistance they require such as assistance in toileting and dressing.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**ALLEGATION:**

**Residents are abused and neglected.**

**INVESTIGATION:**

The complainant alleged that residents are abused and neglected.

On 04/01/2026, I had correspondence with the complainant. The complainant alleged that Resident C and Resident D have been abused by workers at the facility. The complainant alleged that Resident E and Resident F are neglected at the facility.

On 04/15/2026, I interviewed staff person 1 (SP1) by telephone. SP1 reported that Resident D is no longer at the facility and passed away at home. SP1 reported that Resident C can be sexually aggressive with workers. SP1 reported that she never observed workers being aggressive towards Resident C. SP1 reported that Resident F recently moved back to the assisted living unit from the memory care unit to reside with Resident E. SP1 reported that there were some concerns with Resident E having bathroom accidents, but these isolated issues have been addressed. SP1 reported residents are treated appropriately at the facility.

On 04/08/2026, I attempted to interview Resident C at the facility. Resident C was unable to complete the interview due to his cognitive ability. However, I did not observe any signs of abuse or neglect on Resident C.

On 04/08/2026, I attempted to interview Resident E and Resident F. However, these residents were not at the facility.

On 04/08/2026, I interviewed SP3 at the facility. SP3 reported she has never observed signs of abuse with Resident C.

On 04/08/2026, I interviewed SP4 at the facility. SP4 reported that residents are treated respectfully and are provided with appropriate care.

While onsite at the facility. I observed many residents engaged with staff members and in activities at the facility. The residents I observed appeared to be well-kept and the staff were appropriately engaged with the residents.

I reviewed facility chart notes for Resident C. The facility chart notes read,

*“03/27/2026: Resident tried to choke and slap staff when assisting him with getting ready for the day. Resident also would not let go of another staff members arm and was holding it very aggressively squeezing her. Resident also tried to hit his wife.  
03/24/2026: As staff passed residents room, res was observed with penis hanging out so staff check resident and he was covered in urine. Staff alerted care staff. Staff assisted res with getting changed and out of bed. As soon as staff approached resident to check on his, he gripped onto staff arm with all his strength and refused to let go. Staff had to remove his hand. while changing res, res pushed staff against the wall with both arms and his knees and he was getting changed. Res continued to grab onto staff with all his strength the whole time he was being assisted. As well as being aggressive, res continued to yell at staff. Res was changed and assisted out of bed for breakfast.”*

I reviewed facility chart notes for Resident D. The facility chart notes read,

*“01/23/2026: Resident has fallen. Seems to have been trying to get to wheelchair, R arm was around small front wheel. She looks to have fallen face first hitting the R side of her face around her eye. Having pain in her lower neck. Resident stayed in*

*the position she was found in until the rescue teams could assess the situation and took over. She was not able to talk until the first responder was in the building and then only intermittently after. Report finished.*

*01/14/2026: resident had a fall this morning she was tryin to go to the bathroom on her own and manage to get up but when she started walking her catheter got caught on something and she tripped family was notify and pcp was called.”*

<b>APPLICABLE RULE</b>	
<b>R 325.1931</b>	<b>Employees; general provisions.</b>
	<b>(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.</b>
<b>ANALYSIS:</b>	Interviews conducted and observations made revealed lack of evidence to support this allegation.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

**ALLEGATION:**

**Facility has insufficient staff.**

**INVESTIGATION:**

The complainant alleged that there is insufficient staff at the facility.

SP1 reported that there is adequate staff at the facility. SP1 reported that the facility does not go below their staffing ratios. SP1 reported at times family members have said it can be difficult to find staff but there are always staff in the building.

SP2 reported that in memory care there are always two staff members. SP2 reported that in assisted living there are to be three staff members on first and second shift and on third shift there are two staff members. SP2 reported if there is an unexpected staff shortage, a staff member will be mandated to cover that shift and that is reflected on the schedule. SP2 reported that there is also a manager on call 24/7. SP2 reported that there are adequate staff at the facility.

SP3 reported that in memory care there are always two staff members in the unit. SP3 reported that there are adequate staff at the facility to meet the needs of the residents.

I reviewed the staff schedule for 03/22/2026-04/08/2026. The schedule revealed the staffing ratios were met as described by SP2.

<b>APPLICABLE RULE</b>	
<b>R 325.1931</b>	<b>Employees; general provisions.</b>
	<b>(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.</b>
<b>ANALYSIS:</b>	Interviews conducted and review of schedules revealed lack of evidence to support this allegation.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

**ALLEGATION:**

**Medications are left out and medication carts are unlocked.**

**INVESTIGATION:**

The complainant alleged that medications are left out and medication carts are left unlocked.

SP1 reported that there was training provided to care staff on shutting and locking the care station room. SP1 reported that family members were coming into the care station room and this was not appropriate as there is confidential resident information. SP1 reported that there never have been issues with medications left out or medication carts not locked.

SP3 and SP4 reported no issues with medications left unattended or medication carts left unlocked.

At the facility I observed all the medication carts at the facility. The medication carts were all locked. I observed the care station rooms at the facility. The rooms were locked and were not accessible to the public.

At the facility, I observed Resident G's room at the facility. In Resident G's room there were prescription eye drops in the refrigerator in Resident G's room.

<b>APPLICABLE RULE</b>	
<b>R 325.1979</b>	<b>General maintenance and storage.</b>
	<b>(3) Hazardous and toxic materials shall be stored in a safe manner.</b>

<b>ANALYSIS:</b>	Inspection of the facility revealed prescription eye drops were not stored in a safe manner as observed by the eye drops being placed in Resident G's room.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**ADDITIONAL FINDINGS:**

**INVESTIGATION:**

I reviewed the *Medication Pass Exception* report for 04/01/2026-04/08/2026. The report revealed there were 72 instances in which medication was not administered due to the facility waiting for the delivery of medications. In addition, there were eight instances in which the medication was not administered due to medication that could not be found in cart, or the medication was not available.

<b>APPLICABLE RULE</b>	
<b>R 325.1932</b>	<b>Resident medications.</b>
	<b>(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.</b>
<b>ANALYSIS:</b>	Review of facility documentation revealed multiple instances in which residents did not receive medications as prescribed.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED.</b>

**ADDITIONAL FINDINGS:**

**INVESTIGATION:**

Review of Resident G's medication administration record (MAR) for April 2026 revealed the following:

Anti-em Hese Knee: on in the AM off at PM: staff did not initial that this was completed on 04/06/2026 in the PM

Hearing Aids: hearing aids are taken out when you go in for med pass: staff did not initial that this was completed on 04/06/2026

Review of Resident G's MAR for March 2026 revealed the following:

Losartan Pot Tab 100mg: staff did not document that this was administered on 03/17/2026 at 8:00pm

Mirtazapine Tab 45mg: staff did not document that this was administered on 03/17/2026 at 8:00pm

Probiotic Cap: staff did not document that this was administered on 03/17/2026 at 8:00pm

<b>APPLICABLE RULE</b>	
<b>R 325.1932</b>	<b>Resident medications.</b>
	<b>(3) Staff who supervise the administration of medication for residents who do not self-administer shall comply with all of the following: (b) Complete an individual medication log that contains all of the following information: (v) The initials of the individual who administered the prescribed medication.</b>
<b>ANALYSIS:</b>	Review of Resident G's MAR revealed staff did not appropriately document that medications were administered.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED.</b>

**IV. RECOMMENDATION**

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



04/15/2026

\_\_\_\_\_  
Kimberly Horst  
Licensing Staff

\_\_\_\_\_  
Date

Approved By:



04/15/2026

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

\_\_\_\_\_  
Date