STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

ORLENE HAWKS
DIRECTOR

October 6, 2022

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

RE: License #: AH700396224
Investigation #: 2022A1028044
Riley's Grove Assisted Living

Dear Ms. Del Raso:

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 I am not available, and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

Julie Viviano, Licensing Staff
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
Cell (616) 204-4300

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT

I. IDENTIFYING INFORMATION

License #:	AH700396224
Investigation #:	2022A1028044
Complaint Receipt Date:	05/16/2022
Investigation Initiation Date:	05/16/2022
Report Due Date:	07/15/2022
Licensee Name:	Riley's Grove Assisted Living, LLC
Licensee Address:	Ste 200 3196 Kraft Ave. SE Grand Rapids, MI 49512
Licensee Telephone #:	Unknown
Administrator:	Amanda Mlejnek
Authorized Representative:	Carol Del Raso
Name of Facility:	Riley's Grove Assisted Living
Facility Address:	9481 Pentatech Zeeland, MI 49464
Facility Telephone #:	(616) 748-0565
Original Issuance Date:	11/16/2020
License **Status:**	REGULAR
Effective Date:	05/16/2021
Expiration Date:	05/15/2022
Capacity:	70
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
The facility did not appropriately supervise Resident A when outside of the memory care unit.	Yes
Additional Finding	Yes

III. METHODOLOGY

04/21/2022	Contact - Document Received Received 30 Day discharge for Resident A from Administrator Amanda Mlejnek.
05/12/2022	Contact – Face to Face On-site inspection completed
05/12/2022	Contact – Face to Face Interviewed administrator Amanda Mlejnek at the facility.
05/12/2022	Contact – Telephone Call Received Interviewed facility authorized representative, Carol Del Raso, by telephone.
05/12/2022	Contact – Document Requested Requested Resident A's admission contract, original service plan and subsequent service plans, and guardian/POA contact information from administrator Amanda Mlejnek.
05/16/2022	Contact – Document Received Received Facility Memory Care program statement from authorized representative, Carol Del Raso.
05/16/2022	Contact – Document Received Received Resident A's admission contract, original service plan and subsequent service plans, and guardian/POA contact information from administrator Amanda Mlejnek.
05/16/2022	Special Investigation Intake 2022A1028044
05/16/2022	Special Investigation Initiated - Letter 2022A1028044

05/16/2022	APS Referral 2022A1028044 - APS referral sent to Centralized Intake
10/6/2022	Exit Interview

ALLEGATION:

The facility did not appropriately supervise Resident A when outside of the memory care unit.

INVESTIGATION:

On 4/21/2022, the department received 30 Day discharge for Resident A from administrator Amanda Mlejnek.

On 5/12/2022, I completed an on-site inspection. During my inspection I noted the entrance and exits of the building were secure and that the memory care unit is a separate secured unit within the facility that requires a key card to enter and exit. I observed seven residents during mealtime in the memory care unit with an appropriate amount to staff to assist as needed.

On 5/12/2022, I interviewed administrator, Amanda Mlejnek, at the facility. Ms. Mlejnek reported Resident A was allowed to exit the memory care unit without supervision and often ate dinner with assisted living residents. Ms. Mlejnek reported Resident A resides in the memory care unit but often dines in assisted living unsupervised. Resident A recently began to demonstrate behaviors towards staff and other residents in assisted living which required staff to intervene. Ms. Mlejnek reported the memory care unit is considered “free flowing” throughout the building since the building itself is secure. Due to Resident A’s recent behaviors resulting in several incidents while in the assisted living area, the facility issued Resident A a 30-day discharge. I requested Resident A’s admission contract, original service plan and subsequent service plans, and guardian/POA contact information from Ms. Mlejnek.

On 5/12/2022, I interviewed facility authorized representative, Carol Del Raso, by telephone. Ms. Del Raso reported the building is secured under one license and that the memory care unit is considered to “free flowing” throughout the building and memory care residents are allowed to socialize and dine with assisted living residents.

On 5/16/2022, I received the facility memory care program statement from Ms. Del Raso via email.

On 5/16/2022, I received Resident A's admission contract, original service plan and subsequent service plans, and guardian/POA contact information from Ms. Mlejnek.

On 5/16/2022, the Bureau investigation was opened due to Resident A's incident report resulting in a 30-day discharge.

On 5/16/2022, an Adult Protective Services (APS) referral was sent to Centralized Intake.

On 6/2/2022, I reviewed Resident A's admission contract which revealed it is signed by Resident A's authorized representative on 6/21/21.

I reviewed Resident A's service plan which was dated 12/14/20 and not signed by Resident A or their authorized representative. The service plan revealed the following:

- Resident A has occasional confusion and requires prompting and cuing daily.
- Resident A has good safety awareness and may be outside on campus grounds unsupervised but needs supervision to leave campus.
- Resident A requires baseline monitoring at change of each shift, mid-day meal, and once per mid third shift.
- Resident A does not demonstrate wandering, resistive/uncooperative behavior, verbal disruptive behavior, and social disruptive behavior.
- Resident A had a prior head injury that was alcohol related.
- Resident A requires reminders to complete grooming, oral care, and dressing, set up to bathe, and facility staff manage Resident A's medications.
- Resident A has a regular diet and requires reminders for meals.
- Resident A has a diagnosis of dementia, hypertension, arthritis, depression, and prior head injury related to alcohol use.

I reviewed the department facility file for submitted incident reports for Resident A, which revealed only incident report was submitted occurring on 12/21/21. Resident A was in an altercation with another resident in the assisted living area resulting in Resident B incurring a skin scrape. Resident A was redirected, and Resident A's sister was called and took Resident A away from the facility for the remainder of the evening due to the incident.

I reviewed the facility memory care program statement which read:

- *The memory care area of the community is set up as "neighborhoods," creating a smaller, more home-like environment for residents. There are areas of interest throughout the memory care space to assist in providing freedom of movement and purpose-driven activities that will allow our residents to engage in their surroundings either independently or with assistance.*

- *Dining Services: We will have “traveling” food and snacks available for those who do not sit well for meal and may desire more frequent snacks. Our Memory Care staff are encouraged to eat with residents to model eating while also offering a more family style dining program with socialization before, during and following meals. Our household dining areas in Memory Care are intended for only 7 residents to allow for a more dementia friendly environment during meals.*

On 6/2/2022, I reviewed the original facility license study report documentation dated 11/16/2020 and which read:

- *Riley’s Grove Assisted Living is a single-story building with the main entrance (sic)…The main entrance door will be locked 24 hours a day.*

- *The secured memory unit is located to the north off Byron Road corridor. The secured memory unit is comprised of two corridors that contain resident rooms and one spa room. The resident rooms in the secured memory care corridors are studio style ranging from 275 square feet to 384 square feet. The bathrooms in the resident rooms contain a sink and toilet.*

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(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.**

ANALYSIS:	Interviews along with on-site inspection and documentation reveal the facility did not provide Resident A the necessary supervision and/or assistance when Resident A was allowed outside of the memory care unit into the assisted living unit unsupervised. Facility staff did not appropriately provide protection, supervision, and assistance for Resident A or in accordance with the service plan and/or the organized memory care program which resulted in an altercation in assisted living between Resident A and another resident who incurred a skin scrape. Therefore, the facility is in violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

Additional Findings:

On 4/21/2022, a 30-Day discharge for Resident A citing the following:

Rule R325.1922(15) and 1922 (16), Admission and retention of residents, (13) states, "A home shall provide a resident and / or his or her authorized, and the agency responsible for the resident's placement, if any, with a 30-day written notice before discharging from the home.

(a) Substantial risk to the resident due to the inability of the home to meet the resident's needs or assure the safety and well-being of other residents of the home. (b) Substantial risk, or an occurrence, of self-destructive behavior. (c) Substantial risk, or an occurrence, of serious physical assault. (d) Substantial risk, or an occurrence, of the destruction of property.

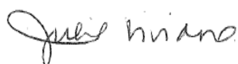
On 6/2/22, I reviewed Resident A's service plan which was last dated 12/14/20 revealing Resident A requires baseline monitoring at change of each shift, mid-day meal, and once per mid third shift. Resident A does not demonstrate wandering, resistive/uncooperative behavior, verbal disruptive behavior, and social disruptive behavior

On 6/2/22, I reviewed the facility incident reports for Resident A, which revealed only one incident report was submitted occurring on 12/21/21. No other reports documenting Resident A's behavior were submitted to the department.

APPLICABLE RULE	
R 325.1922 (5)	**Admission and retention of residents.**
	(5) A home shall update each resident's service plan at least annually or if there is a significant change in the resident care needs. Changes shall be communicated to the resident's authorized representative, if any.
ANALYSIS:	The facility issued Resident A a 30-day discharge on 4/21/22 citing Resident A was demonstrating substantial risk to self, other residents, and property. However, only one incident report was submitted on 12/21/21 to the department by the facility concerning Resident A's behaviors. Resident A's service plan was never updated to document the increasing care needs of Resident A and/or to provide increased assistance and alternatives for behaviors prior to issuing a 30-day discharge. Therefore, the facility is on violation of this rule.
CONCLUSION:	**VIOLATION ESTABLISHED.**

IV. RECOMMENDATION

Contingent upon an approved corrective action plan, I recommend the status of this license remain the same.



6/7/2022

Julie Viviano Date
Licensing Staff

Approved By:

10/05/2022

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