GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

April 20, 2023

Linda Van-Gansbeke
River Inn AFC Inc
241 Grand Ledge Hwy
Sunfield, MI 48890

RE: License #: AL230006951
Investigation #: 2023A1033031
River Inn AFC, Inc.

Dear Ms. Van-Gansbeke:

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,

Jana Lipps, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

## I. IDENTIFYING INFORMATION

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|---|---|
| **License #:** | AL230006951 |
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| **Investigation #:** | 2023A1033031 |
| | |
| **Complaint Receipt Date:** | 02/23/2023 |
| | |
| **Investigation Initiation Date:** | 02/23/2023 |
| | |
| **Report Due Date:** | 04/24/2023 |
| | |
| **Licensee Name:** | River Inn AFC Inc |
| | |
| **Licensee Address:** | 241 Grand Ledge Hwy<br>Sunfield, MI 48890 |
| | |
| **Licensee Telephone #:** | (517) 566-8832 |
| | |
| **Administrator:** | Rhonda Thompson |
| | |
| **Licensee Designee:** | Linda Van-Gansbeke, Designee |
| | |
| **Name of Facility:** | River Inn AFC, Inc. |
| | |
| **Facility Address:** | 241 Grand Ledge Highway<br>Sunfield, MI 48890-9781 |
| | |
| **Facility Telephone #:** | (517) 566-8832 |
| | |
| **Original Issuance Date:** | 06/01/1992 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 03/06/2023 |
| | |
| **Expiration Date:** | 03/05/2025 |
| | |
| **Capacity:** | 20 |
| | |
| **Program Type:** | PHYSICALLY HANDICAPPED<br>ALZHEIMERS<br>AGED |

## II. ALLEGATION(S)

| | **Violation Established**? |
|---|---|
| Direct care staff, MaLinda Taylor, speaks about residents in a derogatory manner. | No |
| Resident A's Meclizine medication was changed from an as needed medication to a routine medication without physician approval. | Yes |
| Resident diabetic diets are not being followed by direct care staff. | Yes |

## III. METHODOLOGY

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|---|---|
| 02/23/2023 | Special Investigation Intake 2023A1033031 |
| 02/23/2023 | Special Investigation Initiated – Telephone call made- Interview with Complainant, via telephone. |
| 02/23/2023 | Contact - Telephone call made- Interview with Citizen 1, via telephone. |
| 03/02/2023 | Inspection Completed On-site- Interview with direct care staff, Kelsey Simpson, Resident A, & Resident B. Review of all 7 resident records, review of Resident A's medications completed. |
| 03/02/2023 | Contact - Telephone call made- Attempt to interview Administrator, Rhonda Thompson, via telephone, voicemail message left. |
| 03/02/2023 | Contact - Telephone call made- Interview with Administrator, Rhonda Thompson, via telephone. |
| 03/09/2023 | Contact - Telephone call made- Attempt to interview direct care staff, Becky, via telephone. Voicemail message left. |
| 03/13/2023 | Contact - Telephone call received- Interview with direct care staff, Becky Champion, via telephone. |
| 03/22/2023 | Contact - Telephone call made- Interview with direct care staff, MaLinda Taylor, via telephone. |
| 03/22/2023 | Inspection Completed-BCAL Sub. Compliance |
| 04/20/2023 | Contact – Telephone call made |

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| | Attempt to interview New Walker Pharmacy, Pharmacy Technician, Betty Jo Rayner. |
| 04/20/2023 | Exit Conference<br>Exit conference conducted via telephone with licensee designee, Linda Van-Gansbeke. |

**ALLEGATION: Direct care staff, MaLinda Taylor, speaks about residents in a derogatory manner.**

**INVESTIGATION:**

On 2/23/23 I received a voicemail message from Complainant, regarding a complaint report regarding the River Inn AFC, Inc. (the facility). On 2/23/23 I interviewed Complainant who reported direct care staff member, MaLinda Taylor speaks about residents, in front of other residents, in a derogatory manner. Complainant reported Citizen 1 has additional information regarding this complaint.

On 2/23/23 I interviewed Citizen 1, via telephone. Citizen 1 reported she has been at the facility when Ms. Taylor has come into Resident A's bedroom and stated, "Well [Resident A], are you ready for our nightly bitch session?" Citizen 1 reported that Ms. Taylor has also been observed stating to Resident A, "If you need to shit tonight make sure you make it to the toilet," and then proceeded to complain about two other residents who had just experienced incontinence of bowel and she had to clean them up.

On 3/2/23 I completed an on-site investigation at the facility. I interviewed direct care staff, Kelsey Simpson. Ms. Simpson reported she has worked at the facility since January 2023. She reported she does not work directly with Ms. Taylor as there is currently one staff member working per shift. Ms. Simpson reported there is some overlap at shift changes and she has observed Ms. Taylor, for short periods of time, interact with the residents. Ms. Simpson reported she has never witnessed Ms. Taylor talk about the residents in a derogatory manner.

On 3/2/23, during on-site investigation, I interviewed Resident A. Resident A reported he has no issues with how Ms. Taylor provides for resident care. Resident A reported, regarding Ms. Taylor, "She would be the last one I'd fire around here." Resident A reported Ms. Taylor does come into his bedroom at night to complain, but he declined to provide further information or details regarding these complaints.

On 3/2/23, during on-site investigation, I interviewed Resident B. Resident B reported that she has no issues with any of the direct care staff. Resident B reported that Ms. Taylor is a good care provider and she's "kind."

On 3/2/23 I interviewed facility Administrator, Rhonda Thompson, via telephone. Ms. Thompson reported she has directly observed Ms. Taylor interacting with residents at the facility. Ms. Thompson reported Ms. Taylor has been counseled, by herself, for swearing in the presence of residents but she has never sworn at a resident in a derogatory manner. Ms. Thompson reported Ms. Taylor is very kind and helpful when providing resident care. She reported she has not received complaints from other residents about Ms. Taylor speaking in a derogatory manner about residents in front of other residents. Ms. Thompson reported Resident A's family members have mentioned observing Ms. Taylor speaking in a derogatory manner about other residents, to Resident A. She reported she asked Ms. Taylor about this allegation and Ms. Taylor denied speaking in a derogatory manner about other residents in the presence of the other residents.

On 3/22/23 I interviewed direct care staff, MaLinda Taylor, via telephone. Ms. Taylor reported that she does not speak about the residents, in front of other residents, in a derogatory manner. She denied these allegations.

| **APPLICABLE RULE** | |
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| **R 400.15304** | **Resident rights; licensee responsibilities.** |
| | **(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights:**<br>**(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.**<br><br>**(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.** |

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| **ANALYSIS:** | Based upon interviews with Ms. Taylor, Ms. Simpson, Ms. Thompson, Citizen1, Resident A and Resident B, there is not adequate evidence direct care staff member Ms. Taylor is not treating the residents with consideration and respect with due recognition of personal dignity, individuality, and the need for privacy. Although Citizen 1 reports directly observing derogatory statements made in the presence of Resident A, Resident A denied that Ms. Taylor is speaking about others in a derogatory manner and declined providing further information when he did acknowledge that she has come into his bedroom to "complain" in the evening hours. There is not adequate evidence to cite this as a violation. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

**ALLEGATION: Resident A's Meclizine medication was changed from an as needed medication to a routine medication without physician approval.**

**INVESTIGATION:**

On 2/23/23 I received a voicemail message from Complainant, regarding an allegation that direct care staff at the facility changed Resident A's Meclizine medication from as needed to routine, without physician approval. On 2/23/23 I interviewed the Complainant, via telephone. Complainant reported Citizen 1 has additional information regarding this complaint.

On 2/23/23 I interviewed Citizen 1 regarding the allegation. Citizen 1 reported Resident A had been experiencing some dizziness and was ordered the medication, Meclizine, by his physician, 3 times per day, as needed, until the dizziness resolved. Citizen 1 reported she was visiting Resident A, at the facility, and noted he was extremely lethargic, which was unusual for his normal mental state. She reported she discovered he had been placed on the Meclizine medication three times per day, routinely, instead of as needed. She reported administrator, Rhonda Thompson, had called the pharmacy and requested that the medication be added to Resident A's daily pill packets as a routine medication given 1 tablet, 3 times per day, instead of as needed for symptom management of dizziness. Citizen 1 reported she contacted the pharmacy and the physician's office regarding the medication administration of the Meclizine. Citizen 1 reported she spoke with Betty Jo Rayner, at the New Walker Pharmacy, who reported she had added the Meclizine to Resident A's routine medications as Ms. Thompson had requested this be done. Citizen 1 reported Ms. Rayner stated Ms. Thompson was aware of the needs of her residents, and she complied with adding the as needed medication to the routine medication daily pill packets as she felt Ms. Thompson had a good understanding of her residents' needs. Citizen 1 reported the facility was contacted, and she spoke with direct care staff, Becky Champion, and requested the Meclizine be removed

from the daily pill packs as a routine medication and be returned to the status of an as needed medication.

On 3/2/23 I completed an on-site investigation at the facility. I interviewed direct care staff, Kelsey Simpson. Ms. Simpson reported Resident A's Meclizine medication was previously in his daily pill packs, delivered from the pharmacy, and being administered as a routine medication for dizziness. She reported that medication was discontinued, as routine, on 2/13/23 and the staff removed the extra doses from the remaining pill packets for the remainder of the month of February 2023.

During on-site investigation, on 3/2/23, I reviewed the Medication Administration Record (MAR) for Resident A for the months of February 2023 and March 2023. On the February 2023 MAR Meclizine 25mg, 3x/day PRN, was written on the MAR and recorded as being administered three times daily from 2/1/23 – 2/12/23. It was also recorded as being administered in the morning and afternoon on 2/13/23. Beyond the date of 2/13/23 the remaining dates had a line drawn through them and it was noted "PRN" under this area of the MAR. On the March 2023 MAR, for Resident A, the Meclizine was typed onto the MAR and noted as follows, "Meclizine 25mg [Antivert 25mg] Take 1 tablet (25mg total) by mouth 3 times daily as needed for dizziness". There were no dates with recorded administrations of this medication on the March MAR. Also, during on-site investigation, I reviewed Resident A's mediations in the medication room. The Meclizine no longer appeared in any of the daily pill packets from the pharmacy. There was one pill card with a PRN supply of Meclizine, available for Resident A's use.

On 3/2/23 I interviewed facility Administrator, Rhonda Thompson, via telephone. Ms. Thompson reported Resident A had been complaining of vertigo late in January 2023 (exact date not recalled). She reported that his daughter was visiting him (she could not recall which daughter) and this daughter offered to call the physician to discuss the dizziness. She reported the daughter relayed to direct care staff, Becky Champion, the physician had ordered Meclizine medication three times daily for Resident A. Ms. Thompson reported that Ms. Champion then called the pharmacy to confirm and see if they would add the medication to Resident A's monthly pill packets for the month of February 2023 before they were sent out to the facility. Ms. Thompson reported that the pharmacy complied with this request and the medication was added three times per day to the daily medication packets. Ms. Thompson reported that neither she, nor Ms. Champion, were able to view a written prescription as the physician's office faxed the script directly to the pharmacy.

On 3/13/23 I interviewed direct care staff, Becky Champion, via telephone. Ms. Champion reported that around the end of January (exact date not specified), Resident A started having issues with vertigo/dizziness. She reported that one of Resident A's daughters (she could not recall which daughter) had called the physician's office and requested a vertigo medication be ordered for Resident A. Ms. Champion reported this daughter then updated Ms. Champion that the physician had ordered the Meclizine medication for Resident A, three times per day, and had the

script sent to the New Walker Pharmacy, where Resident A's mediations are filled. Ms. Champion reported she made a telephone call to the pharmacy and spoke with Betty Jo Rayner. She reported she told Ms. Rayner to add the Meclizine to Resident A's daily pill packets for February as it had been relayed to her, by Resident A's daughter that this mediation was being ordered three times per day. She reported that Ms. Rayner stated, "No problem", and filled the medication. Ms. Champion reported that a paper copy of the prescription for the Meclizine was never received by the facility. She reported that the medication was administered three times daily, routinely, for thirteen days, until Resident A's daughter expressed concern due to Resident A's increased lethargy.

On 4/20/23 I attempted to interview Ms. Rayner via telephone. I made a telephone call to the New Walker Pharmacy and spoke with pharmacy staff who expressed Ms. Rayner was no longer employed by the pharmacy. I was told that Ms. Rayner's role at the pharmacy, while she was employed, was Pharmacy Technician.

| **APPLICABLE RULE** | |
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| **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: (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.** |

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| **ANALYSIS:** | Based upon the interviews with Ms. Simpson, Ms. Thompson, Citizen 1, Ms. Champion, and observations made during my review of Resident A's *Medication Administration Records* for February 2023 and March 2023, it can be determined that the facility Administrator and direct care staff did not obtain written instructions from the physician to adequately understand how the Meclizine medication was being ordered for Resident A's use. Although the pharmacy staff, Betty Jo Rayner, had verbalized understanding of the request to add the medication as a routinely administered medication and complied with adding this medication to Resident A's monthly pill packets, the direct care staff did not take notice of the effects the new medication was having on Resident A, such as extreme lethargy/drowsiness, until Citizen 1 pointed out the change in status and researched the administration record of the medication. At no point did the direct care staff attempt to confirm the actual order, from the physician, prior to administering the medication as a routine medication. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

**ALLEGATION: Resident diabetic diets are not being followed by direct care staff.**

**INVESTIGATION:**

On 2/23/23 I received a voicemail message from Complainant, regarding an allegation that direct care staff at the facility are not following special diets for the residents. On 2/23/23 I interviewed Complainant, via telephone. Complainant reported that Citizen 1 has additional information regarding this allegation.

On 2/23/23 I interviewed Citizen 1 via telephone. Citizen 1 reported Resident A is diabetic, as are other residents in the facility, and direct care staff push sweet treats and desserts toward all residents, including the diabetic residents. Citizen 1 reported that in the evening when the residents receive snack, the snack usually consists of cookies, brownies, ice cream and so forth. Citizen 1 reported that dessert is served with every meal at the facility and there are no exceptions for diabetic residents.

On 3/2/23 I completed an on-site investigation at the facility. I reviewed all the current resident records during this investigation. There were seven residents residing at the facility on this date. Only Resident C had a diabetic diet ordered in her resident file. The remaining six residents had no special diet order listed in their resident records. The diabetic diet for Resident C was noted in her *Assessment Plan for AFC Residents* form, which was dated, 6/15/22. The diabetic diet was also documented on the Hospice of Lansing, *Interdisciplinary Care Plan* form dated

12/02/22. On page 2 of this form, under section, *Problem*, it reads: “4. Altered Metabolic Status – Discipline – Registered Nurse
Goals, 1. River Inn staff will verbalize understanding and demonstrate proper blood sugar testing and contact HOL 24/7 with any questions/concerns/changes with in the next 2 weeks. Start Date – 12/02/2022 – Target Date – 1/31/23
2.River Inn staff will demonstrate effective care management and provide appropriate healthy snacks within the next 2 weeks. Start Date – 12/02/2022 Target Date – 1/31/23.”

During on-site investigation, on 3/2/23, I interviewed direct care staff, Kelsey Simpson. Ms. Simpson reported that the only current resident receiving a special diet is Resident B. She reported that Resident B is now on a low sodium diet as of 3/1/23, after her visit with her physician. Ms. Simpson reported Resident A and Resident C are diabetic but have not been ordered a special diet that she was aware of on this date. Ms. Simpson reported she was not aware of any direct care staff members leaving sweet treats by residents’ bedsides for their evening snack.

During on-site investigation, on 3/2/23, I interviewed Resident B. Resident B reported that the evening snack was generally a cookie, until recently. She reported that recently the evening snacks have been changed to something healthier and now the residents are receiving cheese and crackers, apples and peanut butter and sometimes they will still receive a cookie, or popcorn.

During on-site investigation, on 3/2/23, I interviewed Resident A. Resident A reported he is served a good variety of food at the facility. He reported he is diabetic but not on any diet restrictions, he just needs to “watch” the amount of sugar he has daily. He reported, “I want sugar from time to time.”

On 3/2/23 I interviewed facility administrator, Rhonda Thompson, via telephone. Ms. Thompson reported the only current resident on a special diet at the facility is Resident B. She reported Resident B was recently placed on a low sodium diet on 3/1/23. Ms. Thompson reported residents are offered an 8pm snack and this snack can be a healthy option or ice cream, popcorn, cookie. She reported residents are given a choice of snack if they do not like the option being offered. Ms. Thompson reported the facility does have sugar free cookies as an option for diabetic residents if they want this. She did report that Resident C is not able to speak for herself to decline a sweet treat if one were offered to her. She reported she was unaware that Resident C’s *Assessment Plan for AFC Residents* form indicated a “diabetic diet” and was unaware that the *Interdisciplinary Care Plan* through Hospice of Lansing, also indicated providing Resident C with healthy options due to her diabetes.

On 3/13/23 I interviewed direct care staff, Becky Champion, via telephone. Ms. Champion reported that the only current resident on a special diet is Resident B, who was switched to a low sodium diet on 3/1/23. Ms. Champion reported that the evening snack at 8pm consists of cheese and crackers, granola bars, popcorn, ice

cream, jello, pudding and so forth. She reported that healthy options are available for residents to choose.

On 3/22/23, I interviewed direct care staff, MaLinda Taylor. Ms. Taylor reported that Resident A was recently placed on a diabetic diet. She further reported that the direct care staff watch the food items they provide to Resident C because she is also diabetic.

| **APPLICABLE RULE** | |
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| **R 400.15313** | **Resident nutrition.** |
| | **(3) Special diets shall be prescribed only by a physician. A resident who has been prescribed a special diet shall be provided such a diet.** |
| **ANALYSIS:** | Based upon interviews with Citizen 1, Resident A, Resident B, Ms. Simpson, Ms. Thompson, Ms. Champion, and Ms. Taylor, as well as review of all seven resident records it can be determined direct care staff at the facility were not following the special diabetic diet ordered for Resident C as listed on the Hospice of Lansing, *Interdisciplinary Care Plan*, and also listed on Resident C's *Assessment Plan for AFC Residents* form. Ms. Thompson, Ms. Simpson, and Ms. Champion reported that the only resident who had been ordered a special diet was Resident B, with her newly ordered low sodium diet, when Resident C's diabetic diet is listed on the stated forms, dating back to 6/15/22, as signed on her assessment plan.<br><br>Resident A had no physician ordered special diet per my review of his documents. |
| **CONCLUSION:** | **VIOLATION ESTABLISHED** |

## IV. RECOMMENDATION

Contingent upon receipt of an approved corrective action plan, no change to the status of the license recommended at this time.

04/20/23

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Jana Lipps Date
Licensing Consultant

Approved By:

04/20/2023

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Dawn N. Timm Date
Area Manager