GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 30, 2024

Marie Wieland
Ridgeline Goodrich, LLC
8111 S. State Rd.
Goodrich, MI 48438

RE: License #: AL250417972
Investigation #: 2025A0779001
The Ridge At Goodrich Assisted Living

Dear Marie Wieland:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

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) 643-7960.

Sincerely,

Christopher A. Holvey

Christopher Holvey, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 899-5659

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL250417972
Investigation #:	2025A0779001
Complaint Receipt Date:	10/03/2024
Investigation Initiation Date:	10/03/2024
Report Due Date:	12/02/2024
Licensee Name:	Ridgeline Goodrich, LLC
Licensee Address:	8111 S. State Rd. Goodrich, MI 48438
Licensee Telephone #:	(810) 636-7070
Administrator:	Ruby Kirby
Licensee Designee:	Marie Wieland
Name of Facility:	The Ridge At Goodrich Assisted Living
Facility Address:	8111 S. State Rd. Goodrich, MI 48438
Facility Telephone #:	(810) 636-7070
Original Issuance Date:	08/29/2024
License **Status:**	TEMPORARY
Effective Date:	08/29/2024
Expiration Date:	02/27/2025
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED

II. ALLEGATION(S)

	Violation Established?
No background checks are done for staff.	No
Staff are smoking marijuana during shift and then forgetting to pass residents' medications.	No

III. METHODOLOGY

10/03/2024	Special Investigation Intake 2025A0779001
10/03/2024	Special Investigation Initiated - Telephone Voicemail message left for complainant.
10/08/2024	APS Referral Complaint was referred to APS centralized intake.
10/08/2024	Contact - Telephone call made Spoke to Complainant.
10/10/2024	Inspection Completed On-site
10/10/2024	Contact – Face to face Spoke with Hospice nurse.
10/28/2024	Exit Conference Held with licensee designee, Marie Lynn Wieland.

ALLEGATION:

No background checks are done for staff.

INVESTIGATION:

On 10/8/2024, a phone conversation took place with Complainant, who confirmed that she has never been to this facility and that she received her information second hand. Complainant stated that she was told that this facility does not complete criminal background checks on their staff. Complainant did not have the names of specific staff that are working at this facility who have not had background checks completed.

On 10/10/2024, an unannounced on-site inspection was completed and administrator, Ruby Kirby, was interviewed. Admin Kirby stated that every staff employed at this facility has been fingerprinted and has passed a criminal history check.

During the on-site inspection, a total of 7 direct care staff were interviewed. All 7 staff stated that they have agreed to comply with a criminal history check and have been fingerprinted. They all stated that they did not start work at this facility until the results of those searches deemed them eligible to do so.

Employee records of 8 additional staff persons were reviewed. Every staff file reviewed had documents confirming that the staff had complied with and passed criminal history checks and fingerprinting.

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:	Administrator, Ruby Kirby, stated that every direct staff employed at this facility has passed/completed a criminal history check and fingerprinting. Seven direct care staff interviewed confirmed this fact to be true. Eight additional staff files were reviewed and documents were found confirming that the staff had complied with and passed criminal history checks and fingerprinting. There was no evidence found to warrant a violation of this rule.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Staff are smoking marijuana during shift and then forgetting to pass residents' medication.

INVESTIGATION:

On 10/8/2024, Complainant stated that she was told that staff of this facility are smoking/vaping marijuana outside during their breaks. Complainant was asked for detailed information as to how the residents of this facility have been abused/neglected as a result of staff vaping marijuana. Complainant stated that, after smoking the marijuana, they are forgetting to pass resident's medications. Complainant could not provide any further detailed information, such as which residents were not provided their medications, which medications were not passed, and/or on which dates the medications were not passed.

On 10/10/2024, Admin Kirby stated that this facility has several staff that vape, but that she has no knowledge of any of them having marijuana in their vape pens. Admin Kirby stated that each staff take a half-hour lunch and two 15-minute breaks per shift and that only one staff is allowed on a break at a time. Admin Kirby reported that she is not aware of any staff smelling like marijuana while at work or acting erratic or strangely after taking a break. Admin Kirby stated that they only do drug screening on staff when

there is erratic behavior or a staff injury, which she has not had a reason to do anytime recently. When asked about residents' medications, Admin Kirby stated that residents' medications and medication administration records (MARs) are reviewed often and that she is not aware of any residents not getting their medications. Admin Kirby stated that no residents or families have complained about issues regarding medications.

On 10/10/2024, 7 direct care staff were interviewed separately. All 7 denied vaping/smoking marijuana while on breaks at work or knowing any staff that are doing so. They all stated that they have not smelled marijuana on any other staff or witnessed erratic/strange behavior from a staff after taking a break. All 7 staff reported that they are not aware of any issues regarding residents' medications not being passed and have not observed any extra medication present in the home that should have been passed.

On 10/10/2024, Resident A and Resident B were interviewed separately, but provided the same information. Resident A and Resident B stated that all the staff at this facility are nice, that they have not noticed any staff acting funny or out of the ordinary. They stated that they are getting all their medications. Resident A and Resident B stated that they like living at this facility and that they have no complaints.

During the on-site inspection on 10/10/2024, several other residents were observed to be doing well. They all appeared to be clean and well-groomed.

On 10/10/2024, an in-person conversation took place with Hospice nurse, Jenna Downey, who stated that she is at this facility twice weekly and that she has never witnessed a staff smoking marijuana at the facility, smelling like marijuana or acting funny in any way. Nurse Downey stated that her Hospice patients at this facility get their medications as prescribed and receive good care here.

A review of multiple residents MARs and physical medication bubble packs took place. It appeared that all residents' medications are being passed as prescribed, with meds missing or extra medication being present.

APPLICABLE RULE	
R 400.15204	**Direct care staff; qualifications and training.**
	(2) Direct care staff shall possess all of the following qualifications: **(a) Be suitable to meet the physical, emotional, intellectual, and social needs of each resident.** **(b) Be capable of appropriately handling emergency situations.**

ANALYSIS:	Administrator, Ruby Kirby, is not aware of staff vaping marijuana during their breaks, smelling like marijuana during their shifts or acting erratic or strange after taking a break. Seven direct care staff deny that they vape marijuana while at work or knowing any staff that do so. Resident A and Resident B stated that all the staff at this facility are nice and that they have not noticed any staff acting funny or out of the ordinary. There was insufficient evidence found to warrant violation of this rule.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

APPLICABLE RULE	
R 400.15312	**Resident Medications**
	(2) Medication shall be given. Taken, or applied to pursuant to label instructions
ANALYSIS:	Administrator, Ruby Kirby, is not aware of there being any issues related to resident's medication not being passed. Seven direct care staff reported that they are not aware of any issues regarding residents' medications not being passed and have not observed any extra medication present in the home that should have been passed. Resident A and Resident B stated that they are getting all their prescribed medications. A review of multiple residents MARs and physical medication bubble packs did not reveal any evidence that residents' medications are not being passed as prescribed. There was insufficient evidence found to warrant violation of this rule.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 10/25/2024, an exit conference was held with licensee designee, Marie Wieland. LD Wieland was informed of the outcome of this investigation

IV. RECOMMENDATION

It is recommended that the status of this facility's license remain unchanged.

10/29/2024

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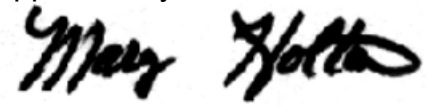
Christopher Holvey Date
Licensing Consultant

Approved By:



10/30/2024

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Mary E. Holton Date
Area Manager