GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 15, 2024

Joy DeVries-Burns
AHR Riverside Grand Rapids MI TRS Sub LLC
18191 Von Karman Ave.
Irvine, CA 92612

RE: License #: AH410397993
Investigation #: 2025A1021003
The Cortland Riverside Gardens

Dear Joy DeVries-Burns:

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 authorized representative 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,
Kimberly Horst

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

License #:	AH410397993
Investigation #:	2025A1021003
Complaint Receipt Date:	10/02/2024
Investigation Initiation Date:	10/02/2024
Report Due Date:	12/01/2024
Licensee Name:	AHR Riverside Grand Rapids MI TRS Sub LLC
Licensee Address:	Ste 300 18191 Von Karman Ave. Irvine, CA 92612
Licensee Telephone #:	(949) 270-9200
Administrator/ Authorized Representative	Joy DeVries-Burns
Name of Facility:	The Cortland Riverside Gardens
Facility Address:	2420 Coit Ave. NE Grand Rapids, MI 49505
Facility Telephone #:	(616) 365-5564
Original Issuance Date:	07/22/2020
License Status:	REGULAR
Effective Date:	02/09/2024
Expiration Date:	07/31/2024
Capacity:	70
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Facility has insufficient staff.	Yes
Residents have increased care needs.	No
Residents do not receive medications.	Yes
Residents do not have hot water.	Yes
Additional Findings	Yes

III. METHODOLOGY

10/02/2024	Special Investigation Intake 2025A1021003
10/02/2024	Special Investigation Initiated – Telephone call message left with complainant
10/04/2024	Inspection completed on site
10/06/2024	Contact-Telephone call made Interviewed SP6
10/08/2024	Contact-Document Received Received Resident E's documents
10/15/2024	Exit Conference

ALLEGATION:

Facility has insufficient staff.

INVESTIGATION:

On 10/02/2024, the licensing department received a complaint with allegations there is insufficient staff at the facility.

On 10/02/2024, the licensing department received another complaint about staffing at the facility. The complainant alleged on 09/30/2024, multiple workers on first shift

did not report to work until hours after their start time. The complainant alleged the facility has over 35 residents and there were only two staff members in the building to care for the residents.

On 10/04/2024, I interviewed administrator Joy DeVries-Burns at the facility. Ms. DeVries-Burns reported the facility has adequate staff. Ms. DeVries-Burns reported the facility has 46 residents. Ms. DeVries-Burns reported for first shift there is to be two caregivers and two medication technicians. Ms. DeVries-Burns reported the facility schedules more people than necessary so that if there is an unexpected call in, the facility does not work short. Ms. DeVries-Burns reported there is always an on-call worker that is also available to assist, if needed.

On 10/04/2024, I interviewed staff person 2 (SP2) at the facility. SP2 reported there is adequate staff at the facility. SP2 reported the facility does not have a mandatory overtime policy. SP2 reported on 09/30/2024, she did receive a few telephone messages that some workers were running late. SP2 reported on 09/30/2024, there were two employees at the start of the shift, 7:00am. SP2 reported these workers were present from third shift. SP2 reported there is no policy that off going shift must stay until the oncoming shift reports. SP2 reported two more employees reported at 0800, and three more employees reported at 0900.

I reviewed a sample of resident service plans. The service plans revealed there were two residents that required two people assist for transfers.

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.**
For Reference: R 325.1901	**Definitions.**
	(16) "Protection" means the continual responsibility of the home to take reasonable action to ensure the health, safety, and well-being of a resident as indicated in the resident's service plan, including protection from physical harm, humiliation, intimidation, and social, moral, financial, and personal exploitation while on the premises, while under the supervision of the home or an agent or employee of the home, or when the resident's service plan states that the resident needs continuous supervision.

ANALYSIS:	Interviews conducted and schedule review revealed the facility worked below their staffing levels on 09/30/2024. Interviews conducted and time stamps reviewed revealed the facility does not have an organized program in place to ensure the protection of the residents when a caregiver is late or absent from their shift.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Residents have increased care needs.

INVESTIGATION:

On 10/02/2024, the licensing department received a complaint that there are residents that require higher level of care at the facility.

On 10/02/2024, I interviewed the complainant by telephone. The complainant alleged Resident E is an amputee and the facility has a difficult time transferring the resident. The complainant alleged Resident E has not received a shower in over two years.

On 10/02/2024, I interviewed SP1 at the facility. SP1 reported Resident E will not allow anyone to transfer her into the shower because she is scared she is going to fall. SP1 reported care staff provide a bed bath to Resident E. SP1 reported Resident E is a large resident, but care staff can provide good care to Resident E.

On 10/02/2024, I interviewed SP3 at the facility. SP3 reported caregivers can provide appropriate level of care to Resident E. SP3 reported Resident E may benefit from a Hoyer lift so that Resident E could get transferred into the shower.

On 10/02/2024, I interviewed SP4 at the facility SP4 reported Resident E does not shower and only receives a bed bath. SP4 reported Resident E is an amputee and uses a slide board for transfers. SP4 reported Resident E could benefit from a Hoyer Lift.

SP2 statements were consistent with those made by SP1.

Ms. DeVries-Burns reported Resident E is scared to transfer into the shower. Resident E reported the facility has been working with Resident E and family on wound care. Ms. DeVries-Burns reported the facility corporate nurse has been assisting with wound care. Ms. DeVries-Burns reported Resident E is currently at the hospital due to the wound.

At the time of my on-site visit, Resident E was at the hospital, and I was unable to interview her.

APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(10) A home shall not retain a resident who requires continuous nursing care services of any kind normally provided in a nursing home as specified in section Page 8 *Courtesy of Michigan Administrative Rules* 21711(3), MCL 333.21711(3), and section 21715(2), MCL 333.21715(2), of the code unless the home meets the provisions of section 21325, MCL 333.21325, of the code or the individual is enrolled in and receiving services from a licensed hospice program or a home health agency.
ANALYSIS:	While Resident E's care needs have increased, the facility is still able to meet the needs of Resident E.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Residents do not receive medications.

INVESTIGATION:

The complainant alleged residents do not receive medications and medications are late. The complainant alleged filled medication cups have been found in the medication carts.

SP1 reported residents do receive their medications. SP1 reported medications may be late, but the medications are still administered. SP1 reported she has not observed filled medication cups in the medication carts.

SP2 reported residents receive their medications. SP2 reported she has not observed filled mediation cups in the medication carts.

I observed the medication carts, and I did not observe any medications in cups.

I reviewed medication administration record (MAR) for multiple residents. The MAR's revealed the following:

Resident A:
Bupropion HC Tab: was not administered this on 09/30 due to drug not available.

Metamucil Powder: was not administered this on 09/30 due to drug not available.
Tolterodine Tab 1mg: was not administered 09/01-09/03 due to drug not available.
Vitamin A & D ointment: was not administered this on 09/03 due to drug not available.

Resident C:
Acetamin Tab 325mg: was not administered this on 09/04,09/23-09/30 due to drug not available.
Biofreeze: was not administered this on 09/03 due to drug not available.
Bupropion Tab 150mg: was not administered this on 09/03-09/06 due to drug not available.
Carvedilol 12.5mg: was not administered this on 09/17 due to drug not available.
Destin: was not administered this on 09/01-09/02, 09/11-09/12, 09/14-09/16, 09/24, 09/26, and 09/28-09/29 due to drug was not available.
Diclofenac: was not administered this on 09/01-09/02, 09/06, 09/11, 09/12, 09/13-09/16, 09/24, 09/28-09/30 due to drug not available.
Nystatin Powder: was to receive 60 doses and missed 18 doses due to drug was not available.
Permethrin Cream: was not administered 09/04, 09/11, 09/25 due to drug was not available.
Quetiapine Tab 25mg: was not administered on 09/22 due to drug was not available.
Quetiapine Tab 50mg: was not administered on 09/01 due to drug was not available.
Senexon: was not administered on 09/19-09/20 due to drug was not available.
Trible Antibiotic Ointment: was to receive 60 doses and missed 24 doses due to drug was not available.

Resident D:
Methotrexate Tab 2.5mg: was not administered on 09/02 and 09/17 due to drug was not available.
Nystatin: was to receive 90 doses but missed 14 doses due to drug was not available.
Silver Sulfa Cream: was not administered 09/19-09/22 due to drug was not available.
Triamcinolone Cream: was to receive 90 doses but missed 21 doses due to drug was not available.

Resident E:
Clindamycin 150mg: was not administered on 9/26 due to drug was not available.
Nystatin Powder: was to receive 81 doses but missed 17 due to drug was not available.
Vitamin D3: was not administered on 09/10 due to drug was not available.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(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.
ANALYSIS:	Review of residents' MARs revealed multiple instances in which the residents did not receive the medications are prescribed by the licensing health care professional.
CONCLUSION:	**VIOLATION ESTABLISHED**

Review of the following residents' MARs revealed there was no staff initials that the resident received the medication.

Resident B:
Levothyroxine Tab 112mcg: no staff initial on 09/08

Resident C:
Iprat/Albut 5-3 mg: no staff initial on 09/01 at 0000 and 0600; 09/03 at 0600, 09/08 at 0600, 09/16 at 0600

Resident D:
Acetaminophen 500mg: no staff initial on 09/12
Biotin Cap 5000mcg: no staff initial on 09/12
Eliquis: no staff initial on 09/12
Nystatin: no staff initial on 09/11, 09/12, 09/15, and 09/22
Silver Sulfa Cream: no staff initial on 09/18
Triamcinolon Cream: no staff initial on 09/11, 09/12, 09/15, and 09/23
Turmeric Cap 500mg: no staff initial on 09/12, 09/15, and 09/22

Resident E:
Gabapentin 300mg: no staff initial on 09/12
Levothyroxine 112mcg: no staff initial on 09/01, 09/08, and 09/15
Nystatin: no staff initial on 09/11, 09/12, and 09/15
Simvastatin 20mg: no staff initial on 09/12

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(3) Staff who supervise the administration of medication for residents who do not self-administer shall comply with all of the following:

	(v) The initials of the individual who administered the prescribed medication.
ANALYSIS:	Review of residents' MARs revealed multiple instances in which the staff member did not initial the MAR that the medication was administered **REPEAT VIOLATION:** **AH410397993_SIR_2024A1021014 CAP dated 12/18/2023.** **AH410397993_SIR_2024A1021045 CAP dated 05/31/2024.** **AH410397993_SIR_2024A1021064 CAP dated 07/03/2024**
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Residents do not have hot water.

INVESTIGATION:

The complainant alleged residents do not have hot water in their rooms. The complainant alleged the water pressure is very weak in the kitchenettes in the residents' rooms.

SP1 reported water temperatures are low in residents' rooms. SP1 reported it is spread out throughout the facility and is not area specific. SP1 reported the water pressure is low in some kitchen areas.

On 10/04/2024, I interviewed SP5 at the facility. SP5 reported he completes water temperature checks every month. SP5 reported if the water temperature is low, he will fix or order a new mixing valve.

I observed a few residents' rooms with SP5. The water temperature was only 90 degrees in one room. In another room, the water pressure was very low in the kitchen area. However, SP5 was able to immediately increase the water pressure.

APPLICABLE RULE	
R 325.1970	**Water supply systems.**
	(7) The temperature of hot water at plumbing fixtures used by residents shall be regulated to provide tempered water at a range of 105 to 120 degrees Fahrenheit.

ANALYSIS:	Observation completed on site revealed the water temperature in resident room was below 105 degrees.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 10/07/2024, I interviewed SP6 by telephone. SP6 reported Resident E had a significant wound on her leg that was at a stage four. SP6 reported she provided a dressing change to Resident E on 09/26/2024, and Resident E was sent out to the hospital a few days later. SP6 reported she is not sure if the dressing change instructions were entered into Resident E's record.

I reviewed discharge paperwork from the wound clinic for Resident E. The paperwork read,

"If dressing is saturated, ok to change the outer dressing and leave packing in place. Packing only needs to be changed once every other day.

1. *Wash your wound with soap and water*
2. *Gently pack wound with iodosorb moistened 2 inch roll gauze. The wound is about 7cm deep.*
3. *Cover your wound with ABD*
4. *Change 3 times weekly.*

Keep your wound covered at all times, wounds do not like to be open to air and need to remain moist and covered.
Elevate your leg(s) about the level of your heart as much as possible throughout the day. Try to elevate your legs for at least one hour at a time three times per day.
Offload pressure to the wound at all times. Any direct pressure to the wound will slow down healing.

Review of Resident E's service plan read,

"able to get out of the bed, chair, car, etc without assistance.
Bathing: Assistance required- specify: transfers in/out, steadying; cueing to wash self; cueing to dry self; shampooing/rinsing/drying hair; applying lotion.
Mobility: Assistive device: Needs occasional assistance with assistive device. Remind to use assistive device if seen without it."

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**

	(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.
ANALYSIS:	Review of Resident E's service plan revealed lack of detail regarding her specific needs. For instance, the plan identified Resident E was able to transfer without assistance. However, interviews conducted revealed Resident E required a slide board to transfer. In addition, Resident E's service plan stated she required an assistive device for mobility, however, it did not state the assistive device and if Resident E was able to use the device independently. In addition, Resident E had a significant wound on her leg and this information was omitted from the service plan.
CONCLUSION:	**VIOLATION ESTABLISHED.**

INVESTIGATION:

Interview with SP2 reported Resident B is on hospice services.

Review of Resident B's service plan revealed no mention of hospice involvement and the role of hospice in Resident B's care.

APPLICABLE RULE	
R 325.1922	**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's care needs. Changes shall be communicated to the resident and his or her authorized representative, if any.
ANALYSIS:	Review of Resident B's service plan revealed it was not reflective of the current care needs of the resident. **REPEAT VIOLATION:** **AH410397993_SIR_2024A1021063 CAP dated 07/01/2024** **AH410397993_SIR_2024A1021014 CAP dated 12/17/2023**
CONCLUSION:	**VIOLATION ESTABLISHED.**

IV. RECOMMENDATION

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

10/09/2024

Kimberly Horst — Date
Licensing Staff

Approved By:

10/15/2024

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