

GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS LANSING

MARLON I. BROWN, DPA DIRECTOR

March 17, 2025

Ronisha Robinson Cliffside Company 3905 Lorraine Path St. Joseph, MI 49085

> RE: License #: AL110077442 Investigation #: 2025A0790017

> > Caretel Inns of Royalton - Dover

Dear Ms. Robinson:

Attached is the Special Investigation Report for the above referenced facility. Due to the violation 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. If I am not available and you need to speak to someone immediately, please contact the local office at (517) 284-9730.

Sincerely,

Rodney Gill, Licensing Consultant Bureau of Community and Health Systems

Rodney Gill

Unit 13, 7th Floor 350 Ottawa, N.W.

Grand Rapids, MI 49503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL110077442
Investigation #:	2025A0790017
Complaint Receipt Date:	03/04/2025
Complaint Receipt Date.	03/04/2023
Investigation Initiation Date:	03/04/2025
Report Due Date:	05/03/2025
Licensee Name:	Cliffside Company
Licensee Address:	3905 Lorraine Path
Licensee Address.	St. Joseph, MI 49085
	G. 6566pH, WII 46666
Licensee Telephone #:	(947) 282-7555
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Administrator:	Ronisha Robinson
Licensee Designee:	Ronisha Robinson
Name of Facility:	Caretel Inns of Royalton – Dover
Name of Facility.	Gareter IIIIIS of Royalton – Bover
Facility Address:	3905 Lorraine Path
-	Saint Joseph, MI 49085
Facility Telephone #:	(269) 363-1906
Original Issuance Date:	08/13/1998
Original Issuance Date:	06/13/1996
License Status:	REGULAR
Effective Date:	12/11/2023
Expiration Date:	12/10/2025
Capacity:	20
Capacity.	20
Program Type:	AGED
	ALZHEIMERS

II. ALLEGATION(S)

Violation
Established?

Staff member physically harmed Resident A.	Yes

III. METHODOLOGY

03/04/2025	Special Investigation Intake 2025A0790017
03/04/2025	APS Referral
	An Adult Protective Services (APS) referral was made via phone.
03/04/2025	Special Investigation Initiated – Letter from licensee designee Ronisha Robinson.
03/13/2025	Inspection Completed On-site
	Interviewed Resident A, direct care staff member Aria Drake, and licensee designee Ronisha Robinson.
03/17/2025	Inspection Completed-BCAL Sub. Compliance
03/17/2025	Corrective Action Plan Requested and Due on 04/01/2025
03/18/2025	Exit Conference with licensee designee Ronisha Robinson.

ALLEGATION:

Staff member physically harmed Resident A.

INVESTIGATION:

On 3/4/25, I reviewed an AFC Licensing Division – Incident / Accident Report dated 3/3/25. The report indicated that on 3/3/25, Resident A approached direct care staff member (DCSM) Eve Kirby while Ms. Kirby was seated in the dining room. Resident A began to stand over Ms. Kirby and swing her arms while yelling. Ms. Kirby extended her leg out in a push motion striking Resident A. Resident A fell onto the ground on her back. Resident A was transferred to the emergency room (ER) for

bleeding.

The report indicated Resident A got up from the ground with assistance from DCSMs. Resident A was seated to apply pressure to bleeding area, 911 and medics called, Ms. Kirby was removed from the facility, Resident A was monitored by DCSMs while medics were in route. Resident A's power of attorney (POA) and DAL were notified.

The report indicated Ms. Kirby was removed from the facility immediately. Resident A returned from the emergency room with no significant injuries. Resident A's primary care physician (PCP) followed up with Resident A the next morning and completed a full assessment with medication management per request of POA. The report indicated licensee designee Ronisha Robinson will require DCSMs to participate in an all-staff in-service education.

The report indicated Resident A received a head laceration from the fall.

On 3/4/25, licensee designee Ronisha Robinson emailed informing me that DCSMs contacted law enforcement, medics, APS, and Resident A's family after the altercation yesterday, 3/3/25, involving Resident A and DCSM Ms. Kirby. Ms. Robinson stated Resident A returned from the ER the same night with no significant injuries. Ms. Robinson said Resident A's family is requesting Resident A remain at the facility.

I conducted an unannounced onsite investigation on 3/13/25. I interviewed Resident A. Resident A stated she likes living at the facility and said the DCSMs take good care of her and the other residents. She said all her needs are met.

Resident A stated she does not remember a whole lot about her fall. She said she remembers she fell on her back and that she went to the hospital. Resident A stated she is feeling well and has no residual pain from the fall.

On 3/13/25, I interviewed DCSM Aria Drake. Ms. Drake said she was working when Resident A fell and witnessed the incident. She stated Resident A was agitated and walking back and forth. Ms. Drake stated Resident A began going through DCSM Eve Kirby's bag. She said Resident A went through Ms. Kirby's bag several times stating that she wanted her clothes. Ms. Drake explained Resident A thought her clothes were in Ms. Kirby's bag.

Ms. Drake said Resident A walked by her and Ms. Kirby again, and once more attempted to get into Ms. Kirby's bag. She stated Ms. Kirby pulled her bag away from Resident A. Ms. Drake said this made Resident A mad, so she jumped in Ms. Kirby's face, and it looked like she was going to hit Ms. Kirby. Ms. Drake said Ms. Kirby leaned back and kicked Resident A to get her away.

Ms. Drake said Resident A stumbled back and fell hitting her head hard on the floor.

Ms. Drake said she rushed over to Resident A and turned her over. She stated she observed blood coming from the back of Resident A's head. Ms. Drake stated she then called licensee designee Ronisha Robinson. She said Ms. Robinson rushed over to where they were at in the facility. Ms. Drake said Ms. Robinson asked Ms. Kirby to leave and had DCSMs call emergency medical services (EMS). Ms. Drake said she held pressure on the back of Resident A's head to help stop the bleeding until EMS arrived.

Ms. Drake said Resident A is currently doing much better mentally, emotionally, and physically. She said Resident A seems much calmer and has more mental clarity. She stated no further incidents have occurred.

On 3/13/25, I interviewed licensee designee Ronisha Robinson and requested additional supporting documentation. Ms. Robinson corroborated the information provided by DCSM Ms. Drake. Mr. Robinson had no additional information to provide regarding the allegation.

On 3/13/25, I reviewed Resident A's *Resident Records*. I specifically reviewed an Order Summary Report. I found Resident A has a diagnosis of dementia unspecified severity with combative behaviors. I found that Resident A has a history of aggressive behaviors and elopement. Resident A is to receive consistent monitoring because of these behaviors.

I reviewed a Progress Note dated 3/4/25. The note was created by Miriam Veldt, MD. The note indicated Resident A is 84 years old and was seen regarding agitation. The note further indicated Resident A does well until about 4:00 p.m. At that point Resident A becomes irritable and ramps up to physical behaviors and agitation most days. The note indicated that last night, Resident A started swinging at a DCSM. The DCSM reacted by kicking Resident A down. Resident A obtained a laceration on the back of her head that did not require stitches. No other injury noted by the emergency room (ER) staff. Resident A had not yet been seen by a psych.

I reviewed Emergency Department (ED) Provider Notes dated 3/3/25. The notes Indicated Resident A was found to have a ground-level fall, a traumatic injury of head, initial encounter, laceration of other part of head without foreign body, initial encounter, and contusion of right forearm, initial encounter. The notes indicated Resident A obtained a head and neck computed tomography (CT) as well as an x-ray of her right forearm. Resident A vitals were stable, and she was at baseline during her examination.

I reviewed an Order Summary Report for Resident A dated 3/13/25. The report indicated that Resident A was prescribed Seroquel Oral Tablets 25 MG (Quetiapine Fumarate) on 3/4/25 for dementia with combative behaviors. The report showed Resident A was prescribed no additional medication.

APPLICABLE RULE		
R 400.15308	Resident behavior interventions prohibitions.	
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following:	
	(b) Use any form of physical force other than physical restraint as defined in these rules.	
ANALYSIS:	Based on the information gathered during this special investigation through review of documentation and interviews with Resident A, DCSM Ms. Drake, and licensee designee Ms. Robinson there was sufficient evidence found indicating on 3/3/25, DCSM Eve Kirby physically harmed Resident A.	
CONCLUSION:	VIOLATION ESTABLISHED	

On 3/18/25, I conducted an exit conference with licensee designee Ronisha Robinson via phone. Ms. Robinson did not dispute the findings or recommendations and agreed to complete a Corrective Action Plan (CAP) within the requested timeframe.

IV. RECOMMENDATION

Russell B. Misiak

Area Manager

Rodney Sell

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

Date

8	3/18/25
Rodney Gill Licensing Consultant	Date
Approved By:	
RussellMisias	3/28/25