GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 26, 2025

Rita Kumar
Riverdale Assisted Living and Memory Care LLC
Suite 300
28592 Orchard Lake Rd.
Farmington Hills, MI 48334

RE: License #: AL500402308
Investigation #: 2025A0617007
Riverdale Assisted Living & Memory Care

Dear Ms. Kumar:

Attached is the Special Investigation Report for the above referenced facility. Due to the severity of the violations, disciplinary action against your license is recommended. *A previous recommendation for revocation was made in Interim Inspection Report dated 12/16/24, which remains in effect.* You will be notified in writing of the department's action and your options for resolution of this matter.

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 (248) 975-5053.

Sincerely,

Eric Johnson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place, Ste 9-100
3026 W Grand Blvd.
Detroit, MI 48202
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL500402308
Investigation #:	2025A0617007
Complaint Receipt Date:	03/17/2025
Investigation Initiation Date:	03/17/2025
Report Due Date:	05/16/2025
Licensee Name:	Riverdale Assisted Living and Memory Care LLC
Licensee Address:	Suite 300 - 28592 Orchard Lake Rd. Farmington Hills, MI 48334
Licensee Telephone #:	(586) 493-7300
Administrator:	Rita Kumar
Licensee Designee:	Rita Kumar
Name of Facility:	Riverdale Assisted Living & Memory Care
Facility Address:	44315 N. Gratiot Clinton Twp., MI 48036
Facility Telephone #:	(586) 493-7300
Original Issuance Date:	05/31/2023
License Status:	1ST PROVISIONAL
Effective Date:	10/16/2024
Expiration Date:	04/15/2025
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A fell in the bathroom and broke his hip. Resident A crawled to his bed and then fell out of the bed a second time.	Yes

III. METHODOLOGY

03/17/2025	Special Investigation Intake 2025A0617007
03/17/2025	Special Investigation Initiated - Letter Email sent to the Complainant
03/18/2025	Contact - Telephone call made I interviewed Resident A's daughter
03/18/2025	Contact - Document Received Resident A's daughter sent me a copy of the voicemail that Resident A left for her.
03/20/2025	Inspection Completed On-site I completed an unannounced onsite investigation at the Riverdale facility. During the onsite investigation, I interviewed staff Tionna Bell, Deshawna Carrencejie, Director of wellness Patrica Conner, Executive Director Brian Radyko and Licensee Designee Rita Kumar (Via phone).
03/20/2025	Contact - Telephone call made TC to Lekiesha Jenkins
03/20/2025	Contact - Telephone call made TC to Regina Jones
03/20/2025	Contact - Telephone call made TC to Dlorian Jordan
03/25/2025	Contact - Telephone call made I interviewed Ms. Lakiesha Jenkins
03/25/2025	Contact - Telephone call made TC to Resident A's son

03/26/2025	Exit Conference Held an exit conference with licensee designee Rita Kumar

ALLEGATION:

Resident A fell in the bathroom and broke his hip. Resident A crawled to their bed and then fell out of the bed a second time.

INVESTIGATION:

On 03/17/25, I received a complaint on the Riverdale Assisted Living and Memory Care facility. According to the complaint, Resident A fell in the bathroom and broke his hip. Resident A crawled to his bed and then fell out of the bed a second time. The caregiver came into the room and placed Resident A on the bed, then called the family member and notified them of the fall. The caregiver did not assess Resident A to see if they could walk. The caregiver left Resident A on his bed without checking on him. A family member came to check on Resident A 30-45 minutes after receiving the call from the caregiver and the family member found Resident A on the floor. Resident A could not walk and was in extreme pain at time the ambulance was contacted. When the EMT technician arrived, it was asked if the resident was on blood thinners, and the caregiver said no. Resident A has blood clots in his legs and therefore is on blood thinners. Additionally, the technician asked if the resident fell on his head, the caregiver said no, which the resident did. The caregivers are not well trained at the facility.

On 03/18/25, I interviewed Resident A's daughter. According to Resident A's daughter, Resident A fell on 02/02/25 around 8am. When he fell, he called his daughter and left a voicemail stating that he fell on the floor, hit his head and was in pain. Resident A's daughter said that around 10am, the facility called her home and told her daughter that Resident A fell. The worker did not notify the family that Resident A was in pain or that he hit his head. Resident A's daughter stated that she contacted her brother and asked that he go to the facility to check on Resident A. Resident A's son arrived at the facility around 10:30am and when he went into Resident A's room, he found him on the floor and in pain. According to Resident A's daughter, after Resident A fell the first time, staff put him back to bed and left him unattended which resulted in a second fall. Staff were unaware of the second fall and at the request of Resident A's son, EMS was contacted. Resident A's daughter stated that when EMS arrived, it was asked if the resident was on blood thinners, and the caregiver said "no". Resident A has blood clots in his legs and therefore is on blood thinners. Additionally, the technician asked if the resident fell on his head, the caregiver said "no", which the resident did. Resident A's daughter stated that Resident A suffered a broken hip and had to have emergency surgery on 02/03/25.

Resident A's daughter stated that staff do not check on residents regularly. She recalled a time in January 2025 when she came to visit Resident A at the facility, and he was in the shower unattended for over 30 minutes while she waited. During that duration, no

staff went to check on Resident A to ensure his safety and well-being. Resident A's daughter sent me a copy of the voicemail that Resident A left for her. According to the screenshot of the call log, Resident A called and left a voicemail at 8:55am on 02/02/25. During the voicemail, Resident A can be heard stating that he fell, hit his head and was in pain. Resident A's voice sounded as if he was in distress. Resident A's daughter also sent me medical documentation (diagnostic radiology report) showing that Resident A had emergency surgery at McLaren Macomb Hospital on 02/03/25 for a fractured hip. The report states that Resident A had Spot Fluoroscopy of the left hip.

On 03/20/25, I completed an unannounced onsite investigation at the Riverdale facility. During the onsite investigation, I interviewed staff Tionna Bell, Deshawna Carrencejie, Director of wellness Patrica Conner, Executive Director Brian Radyko and Licensee Designee Rita Kumar (via phone).

According to Ms. Patricia Conner, on 02/02/25, staff Lakiesha Jenkins called her about 10:30am and told her that when she came into work around 7am, she passed morning meds and did her rounds when she discovered Resident A on the floor of his room. Ms. Jenkins told Ms. Conner that she checked Resident A for injuries and did not observe any injuries. However, Resident A told her that he was in pain on his side. Ms. Conner instructed Ms. Jenkins to call Resident A's family to see if they wanted to send Resident A to the hospital. Ms. Jenkins told Ms. Conner that Resident A did not want to go to the hospital, and she called the family but they did not answer. Ms. Jenkins put Resident A back to bed.

Later that morning, Ms. Jenkins called Ms. Conner back and said that Resident A wanted to go to the hospital and Ms. Conner told her to send him out. According to Ms. Conner, on 02/03/25, Resident A's son came to the facility and questioned Ms. Conner about Resident A's falls. Ms. Conner stated that she was unaware of Resident A falling a second time. Resident A's son notified Ms. Conner that when he arrived at the facility on 02/02/25, he found his father on the floor next to his bed in extreme pain. Ms. Conner then called Ms. Jenkins into the office and Ms. Jenkins admitted that Resident A fell a second time. Ms. Conner then had Ms. Jenkins fill out a second incident report for the second fall. Ms. Conner stated that the facility followed protocol and procedures. According to Ms. Conner, residents are checked on every two hours. Ms. Conner stated that residents have the right to fall and she doesn't know how Resident A's fall could've been prevented.

According to Mr. Brian Radyko, the facility has been doing well and has not had any incidents since the last special investigation in August 2024.

According to Ms. Rita Kumar, she was unaware of Resident A falling and would have to investigate the situation. Ms. Kumar stated that Ms. Conner or Mr. Radyko did not inform her of Resident A's fall and injuries.

During the onsite investigation, I reviewed two incident reports for Resident A. Both reports were dated 02/02/25. The first incident report was completed by Ms. Lakiesha

Jenkins and stated that at 7am, Resident A stated that he fell on the way to the bathroom and crawled back into bed. The second incident report completed by Ms. Jenkins stated that Resident A's son went into the room and discovered Resident A on the floor laying on his left side. Resident A was picked up and placed on the bed. Staff evaluated him for injuries and called EMS.

On 03/25/25, I interviewed Ms. Lakiesha Jenkins. According to Ms. Jenkins, on 02/02/25, she came to work at 7am and did her rounds checking on the residents. Ms. Jenkins observed Resident A sitting on the side of the bed. Ms. Jenkins went to pass medications and when she returned to Resident A's room, he stated that he had fell earlier that morning and his hip hurt. Ms. Jenkins left out the room to go get some pain medication for Resident A, when she returned, he was on the floor. Ms. Jenkins went and got the other staff on shift, Ms. Regina Jones, to help get Resident A back in bed. Ms. Jenkins stated that she assessed him for pain and he did not say anything about hitting his head. Ms. Jenkins stated that she called Ms. Conner and then the family to let them know that Resident A had fell. Soon after, Resident A's son arrived at the facility and went to check on his dad. When he went into the room, he found Resident A on the floor. Ms. Jenkins stated that Resident A's son picked Resident A and put him back in bed. Resident A was in a lot of pain and the son requested that EMS be called. Ms. Jenkins stated that she called Ms. Conner back and notified her of the situation. When EMS arrived, Resident A told them that he hit his head that morning when he fell walking back from the bathroom.

On 03/26/25, I conducted an exit conference with licensee designee Rita Kumar to discuss the findings of this report. Ms. Kumar did not answer and a voicemail was left for her.

APPLICABLE RULE	
R 400.15305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Resident A was found on the floor by staff Lakeisha Jenkins on the morning of 02/02/25. It is unknown how long Resident A was left on the floor unattended. Resident A used his cell phone to call his daughter and desperately call for help. On the voicemail left by Resident A, he stated that he hit his head, was in pain and didn't think staff was going to help him. After Resident A was assisted off of the floor by staff, Resident A was then observed on the floor a second time when his son arrived at the facility. The direct care on shift failed to provide Resident A with proper supervision and care as defined by the act.

CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference SIR #2024A0617027 dated 08/30/24, CAP dated 10/11/24** **SIR #2024A0617005 dated 12/19/23, CAP dated 1/31/24**

APPLICABLE RULE	
R 400.15201	**Qualifications of administrator, direct care staff, licensee, and members of household; provision of names of employee, volunteer, or member of household on parole or probation or convicted of felony; food service staff.**
	(9) A licensee and the administrator shall possess all of the following qualifications: **(a) Be suitable to meet the physical, emotional, social, and intellectual needs of each resident.**
ANALYSIS:	Over the last several months, the Riverdale facility has had a renewal inspection and four special investigations which all concluded with severe violations. Ms. Kumar has failed to bring the facility into compliance with AFC rules and regulations. I have provided Ms. Kumar with technical assistance on numerous occasions however, she has remained hands off from the facility. Ms. Kumar has hired multiple people to run the day-to-day operations of the facility and has not taken responsibility to rectify the violations; the residents continue to suffer as a result. Ms. Kumar continues to fail to demonstrate that she is suitable to meet the physical, emotional, and intellectual needs of each resident.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference SIR #2024A0617027 dated 08/30/24, CAP dated 10/11/24**

APPLICABLE RULE	
R 400.15310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	Resident A was found on the floor by staff Lakeisha Jenkins on the morning of 02/02/25. After Resident A was assisted off of

	the floor by staff, he was put back to bed and medical services were not contacted. Staff did not contact medical services until Resident A was discovered on the floor a second time by his son. Resident A's son demanded that Resident A be sent to the hospital. Resident A suffered a fractured hip and required emergency surgery.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference SIR #2024A0617027 dated 08/30/24 and CAP dated 10/11/24**

ADDITIONAL FINDINGS:

INVESTIGATION:

During the onsite inspection, I reviewed resident files, staff schedules, staff files and completed a medication audit. According to staff schedules, on 02/02/25, Lakiesha Jenkins and Regina Jones worked from 7am to 3pm, Deshawna Carrencejie and Courtney Jones worked from 3pm to 11p, Dlorian Jordan worked 11pm to 7am.

According to my medication audit for Resident B, the following medications were not initialed/given on 3/9/2025, at 8pm: Acetaminophen 325mg, Atorvastatin 10mg, Donepezil HCL 10mg, Famotidine 20mg, Melatonin 3mg, Stool softener.

According to the staff files, Lakiesha Jenkins file only had one verified reference check, no annual health statement, no signed Personnel policies, and no personal care, supervision and protection training. Regina Jones file did not have signed personnel policy.

APPLICABLE RULE	
R 400.15204	**Direct care staff; qualifications and training.**
	(3) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be competent before performing assigned tasks, which shall include being competent in all of the following areas: **(d) Personal care, supervision, and protection.**

ANALYSIS:	During the onsite investigation, I observed that staff Lakeisha Jenkins file did not contain personal care, supervision and protection training.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference SIR #2024A0617018 dated 07/10/24, CAP dated 7/26/24** **SIR #2024A0617027 dated 08/30/24, CAP 10/11/24**

APPLICABLE RULE	
R 400.15205	**Health of a licensee, direct care staff, administrator, other employees, those volunteers under the direction of the licensee, and members of the household.**
	(6) A licensee shall annually review the health status of the administrator, direct care staff, other employees and members of the household. Verification of annual reviews shall be maintained by the home and shall be available for department review.
ANALYSIS:	During the onsite investigation, I observed that staff Lakeisha Jenkins file did not contain an annual health statement.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.15208	**Direct care staff and employee records.**
	(1) A licensee shall maintain a record for each employee. The record shall contain all of the following employee information: **(f) Verification of reference checks.** **(h) Medical information, as required.** **(i) Required verification of the receipt of personnel policies and job descriptions.**

ANALYSIS:	During the onsite investigation, I observed that staff Lakeisha Jenkins file only had one verified reference check, no annual health statement and no signed personal policies. I also observed that Regina Jones file did not have signed personnel policy.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference SIR #2024A0617018 dated 07/10/24, CAP dated 7/26/24** **SIR #2024A0617027 dated 08/30/24, CAP dated 10/11/24**

APPLICABLE RULE	
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: **(b) Complete an individual medication log that contains all of the following information:** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.**
ANALYSIS:	During the onsite investigation, I completed a medication audit. According to the medication audit for Resident B, the following medications were not initialed/given on 3/9/2025, at 8pm: Acetaminophen 325mg, Atorvastatin 10mg, Donepezil HCL 10mg, Famotidine 20mg, Melatonin 3mg, Stool softener.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **Reference SIR #2024A0617027 dated 08/30/24, CAP dated 10/11/24** **SIR #2024A0617018 dated 07/10/24, CAP dated 7/26/24** **Renewal Inspection dated 12/19/23 and CAP dated 01/26/24**

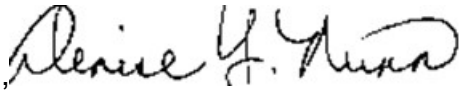
IV. RECOMMENDATION

I recommend revocation and summary suspension of the license.

03/26/25

Eric Johnson Date
Licensing Consultant

Approved By:



03/26/2025

Denise Y. Nunn Date
Area Manager