GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 24, 2026

Carol DelRaso
Riley's Grove Assisted Living
9481 Pentatech
Zeeland, MI 49464

RE: License #: AH700396224
Investigation #: 2026A1021047
Riley's Grove Assisted Living

Dear Carol DelRaso:

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) 335-5985.

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 #:	AH700396224
Investigation #:	2026A1021047
Complaint Receipt Date:	07/01/2026
Investigation Initiation Date:	07/07/2026
Report Due Date:	09/01/2026
Licensee Name:	Riley's Grove Assisted Living, LLC
Licensee Address:	Ste 200 3196 Kraft Ave. SE Grand Rapids, MI 49512
Licensee Telephone #:	(616) 748-0565
Administrator/ Authorized Representative:	Carol DelRaso
Name of Facility:	Riley's Grove Assisted Living
Facility Address:	9481 Pentatech Zeeland, MI 49464
Facility Telephone #:	(616) 748-0565
Original Issuance Date:	11/16/2020
License Status:	REGULAR
Effective Date:	08/01/2026
Expiration Date:	07/31/2027
Capacity:	70
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A had an improper managed choking incident.	No
The facility did not follow physician orders after the incident.	Yes
Additional Findings	No

III. METHODOLOGY

07/01/2026	Special Investigation Intake 2026A1021047
07/07/2026	Special Investigation Initiated - On Site
07/08/2026	Contact-Telephone call made Interviewed SP3
07/13/2026	Contact-Telephone call made Interviewed complainant
07/13/2025	Contact-Telephone call made Interviewed PCP office
07/15/2026	Contact-Telephone call made Interviewed authorized representative
07/24/2026	Exit Conference

ALLEGATION:

Resident A had an improper managed choking incident.

INVESTIGATION:

On 07/01/2026, the licensing department received a complaint with allegations that Resident A had a choking incident at the facility. The complainant alleged that Resident A was interrupted during a meal and taken to the shower while chewing food. The complainant alleged that staff were aware that Resident A was chewing food. The complainant alleged that while in the shower, Resident A began choking and was able to say, “I think I’m choking.” The complainant alleged that staff did not

know what to do and did provide a glass of water. The complainant alleged that neither family nor physician was notified and that no medical care was provided.

On 07/07/2026, I interviewed Resident A at the facility. Resident A reported she eats all meals in her room. Resident A reported that a caregiver came into her room and said that it was time to take a shower. Resident A reported that she took a bite of meat and procced to get into the shower. Resident A reported that while in the shower she started to cough and feel like she was choking. Resident A reported she asked caregivers for a glass of water and she was able to clear the food. Resident A reported she felt like something was stuck in her throat for the rest of the day. Resident A reported that the employee acted like she had no idea what to do when the incident occurred.

On 07/07/2026, I interviewed staff person 1 (SP1) at the facility. SP1 reported that it was reported to her by the on-call person that Resident A coughed on food during a meal service and water was provided to Resident A. SP1 reported that to her knowledge there was no choking as Resident A was able to still breathe and talk during the incident. SP1 reported that Resident A's physician just put in orders for Resident A's meat to be cut up. SP1 reported this was not a reportable incident because there was no choking.

On 07/07/2026, I interviewed SP2 by telephone. SP2 reported she was called into Resident A's room by SP3 because Resident A was about to take a shower and SP3 had to administer medications. SP2 reported that when she entered the room, Resident A was going to the bathroom. SP2 reported that she assisted Resident A into the shower and during the shower Resident A started to cough. SP2 reported that during this incident, Resident A asked for a glass of water, and it was provided to her. SP2 reported that Resident A stopped coughing and the shower continued. SP2 reported that Resident A reported that she would call family. SP2 reported that she informed the on-call and wrote a progress note. SP2 reported that she was unaware that Resident A had food in her mouth. SP2 reported that there was no need for a Helmick Maneuver or CPR as Resident A was able to move air and talk during the incident.

On 07/08/2026, I interviewed SP3 by telephone. SP3 reported she entered Resident A's room to provide medications. SP3 reported Resident A took the medications and then requested a shower. SP3 reported she assisted Resident A in the bathroom and then SP2 assisted with the shower. SP3 reported she did not know that Resident A that had food in her mouth.

I reviewed SP2 and SP3's employee records. Both employees were trained in First Aid and CPR.

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.**
	(p) "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 revealed Resident A did cough on food in the shower but there was no choking involved. When Resident A coughed, water was provided and Resident A was able to clear the food. In addition, the physician has now provided an order for meat to be cut. There is lack of evidence to support the allegation that staff did not appropriately respond to Resident A.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

The facility did not follow physician orders after the incident.

INVESTIGATION:

The complainant alleged Resident A's physician provided orders to check Resident A's temperature, blood pressure, pulse ox, and respiratory signs for five days following the incident. The complainant alleged that for two days the vital signs were taken but not for five days as prescribed by the physician.

On 07/13/2026, I interviewed Optimal Care physician office by telephone. The office reported that on 06/26/2026 an order was faxed to the facility that stated, "*Obtain full*

set of vitals for five days of BP, Heart Rate, Temperature, Respiratory, and Pulse Ox. Notify PCP if HR is greater than 150, Temperature greater than 99.8, and Pulse Ox greater than 92."

On 07/15/2026, I interviewed Carol DelRaso facility authorized representative (AR) by telephone. The AR reported that she was in the facility when Relative A1 contacted her to inform her of the choking incident. The AR reported she checked on Resident A and Resident A provided details on the incident. The AR reported that Relative A1 did speak with the PCP office on getting orders for vital signs. The AR reported the following day she completed a video visit with a facility caregiver in Resident A's room. The AR reported Resident A was at baseline and only complained of a sore throat. The AR reported vital signs were to be taken for five days.

On 07/15/2026, I obtained Resident A's vital sign report. The report revealed that Resident A's temperature was taken 06/27 and 06/28, O2 stats taken 06/27 and 06/28, and blood pressure taken 06/26-07/01.

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:	Interviews conducted and review of documentation revealed the facility did not follow physician orders and obtain all requested vital signs for five days after the incident.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

07/15/2026

Kimberly Horst Date
Licensing Staff

Approved By:

07/23/2026

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