GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 30, 2026

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

RE: License #: AH700396224
Investigation #: 2026A1028054
Riley's Grove Assisted Living

Dear Carol Del Raso:

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 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. In the event I am not available, and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

Julie Viviano

Julie Viviano, Licensing Staff
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

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

I. IDENTIFYING INFORMATION

License #:	AH700396224
Investigation #:	2026A1028054
Complaint Receipt Date:	06/01/2026
Investigation Initiation Date:	06/02/2026
Report Due Date:	08/01/2026
Licensee Name:	Riley's Grove Assisted Living, LLC
Licensee Address:	Ste 200, 3196 Kraft Ave. SE Grand Rapids, MI 49512
Licensee Telephone #:	Unknown
Authorized Representative/Administrator:	Carol Del Raso
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:	08/01/2025
Expiration Date:	07/31/2026
Capacity:	70
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A developed a decubitus ulcer on [their] bottom because staff did not position or rotate [them] in a timely manner; and that Resident A is not fed.	No
Staff leave pills in the medication carts.	No
Residents are served spoiled food and milk.	Yes
Chemicals such as soap are not stored safely in the memory care unit.	Yes
Additional Findings	No

III. METHODOLOGY

06/01/2026	Special Investigation Intake 2026A1028054
06/02/2026	Special Investigation Initiated - Letter
06/02/2026	APS Referral
06/02/2026	Contact - Face to Face Interviewed Employee A at the facility.
06/02/2026	Contact - Face to Face Interviewed Employee B at the facility.
06/02/2026	Contact - Document Received Received the requested documentation from Employee B at the facility.
06/02/2026	Inspection Completed On-site Completed onsite inspection due to this special investigation.
06/02/2026	Contact – Document Received Received an email from the facility authorized representative/administrator requesting information about the onsite visit today due to [them] not being at the facility during the onsite investigation.

06/02/2026	Contact – Document Sent Sent the facility authorized representative/administrator a return email about the onsite investigation visit and findings.
06/09/2026	Contact – Document Sent Emailed the complainant requesting additional details/information about the allegation that *'the facility lets employees leave pills in carts.'*
06/17/2026	Comment At the time of the submittal of this report on 6/17/2026, the complainant has not returned my request for additional clarifying information related to the allegation of *'the facility lets employees leave pills in carts.'*

This investigation will only address allegations pertaining to potential violations of the rules and regulations for Homes for the Aged (HFA). This investigation will not address the allegation that *'the facility hasn't provided the right care for residents. Most of the residents is not getting the right cares'* because it was recently addressed in special investigation 2026A1021035. This investigation will not address the allegations about interpersonal conflicts between employees because it does not pertain to potential violations of HFA rules and regulations. This investigation will not address the allegations of employer and employee work environment conflicts because it does not pertain to potential violations of HFA rules and regulations.

ALLEGATION:

Resident A developed a decubitus ulcer on [their] bottom because staff did not position or rotate [them] in a timely manner; and that Resident A is not fed.

INVESTIGATION:

On 6/1/2026, the Bureau received the allegations through the online complaint system.

On 6/2/2026, I interviewed Employee A at the facility who reported Resident A does have decubitus ulcers but is actively declining and is receiving hospice services. The hospice team monitors all care for Resident A to include skin integrity. Employee A also reported that due to Resident A's decline in health, Resident A's appetite has also declined and [they] have a physician ordered special diet. Employee A reported no knowledge of Resident A not being provided with [their] specialized diet and reported that all staff follow Resident A's current service plan.

On 6/26/2026, I interviewed Employee B at the facility who confirmed that Resident A is actively declining and that hospice services monitor Resident A's current

decubitus ulcer, care, and specialized diet. Resident A was admitted to hospice services on 7/19/2025 with hospice staff and facility staff monitoring Resident A's skin integrity regularly. Resident A first developed the decubitus ulcer in October 2025 with Employee B reporting that to [their] knowledge, facility staff follow all physician and hospice recommendations for Resident A's care and skin integrity. Employee B also confirmed that Resident A's appetite varies and that staff provide Resident A [their] physician ordered special diet. Also, Resident A's food intake has been tracked intermittently by hospice services since January 2026. Employee B provided me with the requested documentation for my review.

On 6/9/2026, I reviewed the requested documentation which revealed the following:
Review of Resident A's service plan:

- Resident A requires assistance with mobility. Assistive devices such as Halo bars, a Hoyer lift, and a high back wheelchair are currently utilized by staff to assist Resident A with mobility.
- Staff provide Resident A assistance with transfers and positioning but there is no evidence that Resident A is on a physician ordered rotation schedule. However, there is evidence that Resident A has physician ordered wound care that is monitored by hospice services and facility staff. Also, there is evidence that staff are present and assist Resident A with all transfers.
- Resident A is a fall risk due to Parkinson's disease diagnosis and receives hourly assurance checks. Physician ordered pressure alarms were ordered in December 2025 and are currently utilized with Resident A.
- Resident A has a physician ordered special diet of pureed diet with nectar thickened liquids.
- Resident A requires assistance with eating, grooming, bathing, dressing, and toileting due to bowel and bladder incontinence.
- The facility manages Resident A's special diet during mealtimes, laundry, housekeeping tasks, and medication administration.
- Resident A receives routine weekly hospice visits due to a decline in health.

Review of record notes:

- There is evidence in the record that Resident A has a special diet due to the decline in health.
- There is evidence in the record that Resident A's decubitus ulcer has been monitored by hospice services since October 2025.
- There is evidence in the record that Resident A's food intake has been tracked by hospice services intermittently since January 2026.

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:	It was alleged that Resident A developed a decubitus ulcer on [their] bottom because staff did not position or rotate [them] in a timely manner; and that Resident A is not fed. Interviews, onsite investigation, and review of documentation reveal there is no evidence to support this allegation. The facility demonstrates care in accordance with current physician orders and the service plan. No violation found.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Staff leave pills in the medication carts.

INVESTIGATION:

On 6/2/2026, Employee A reported the medication kept in the medication carts is medication to be administered to the residents only. Employee A reported that the medication carts are audited weekly to ensure accuracy and compliance and there have been no issues with any of the medication carts. Employee A provided me with the requested documentation for my review.

On 6/2/2026, Employee B's statement was consistent with Employee A's statement.

On 6/2/2026, I reviewed the medication cart audit records for May 2026 and had no concerns.

On 6/2/2026, I completed an inspection of the facility to include the medication carts. No concerns were noted during the inspection and the medication carts observed were organized and neat. I also observed a resident's medication administration completed by facility staff and had no concerns.

**Please note that at the time of the submittal of this special investigation report on 6/17/2026, the complainant has not returned my request for additional clarifying information related to the allegation of *'the facility lets employees leave pills in carts.'*

APPLICABLE RULE	
R 325.1932	**Resident's medications.**
	(3) Staff who supervise the administration of medication for residents who do not self-administer shall comply with all of the following: **(a) Be trained in the proper handling and administration of the prescribed medication.**
ANALYSIS:	It was alleged that staff leave their pills in the medication carts. Interviews, onsite investigation, and review of documentation reveal there is no evidence to support this allegation. The facility demonstrates appropriate medication cart organization along with medication administration for residents. No violation found.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Residents are served spoiled food and milk.

INVESTIGATION:

On 6/2/2026, Employee A reported that to [their] knowledge no resident has ever been served spoiled food or milk. Employee A reported the kitchen staff works hard to ensure meals are prepared and served in accordance with food safety standards and HFA rules and regulations.

On 6/2/2026, Employee B's statement was consistent with Employee A's statement.

On 6/2/2026, due to this special investigation, I completed an inspection of the kitchen and found several cold food items and dry storage items that were opened, but the food items did not have an open date on them. I also found food items in the memory care unit refrigerator that were opened but not labeled with the appropriate open date. No spoiled milk or food was found during the facility inspection.

APPLICABLE RULE	
R 325.1976	**Kitchen and dietary.**
	(6) Food and drink used in the home shall be clean and wholesome and shall be manufactured, handled, stored, prepared, transported, and served so as to be safe for human consumption.

ANALYSIS:	It was alleged that residents are served spoiled food and milk. Interviews and onsite investigation revealed that while there was no spoiled food or milk found, there were many food items found in the main kitchen and memory care unit refrigerator that were not labeled with the appropriate open date. Due to this, it could not be determined if the food items were handled, stored, prepared, and/or served safely for human consumption. Therefore, the facility is in violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Chemicals such as soap are not stored safely in the memory care unit.

INVESTIGATION:

On 6/2/2026, Employee A reported that soap bottles are not left out in the memory care unit and that staff, residents, visitors etc. have access to the wall mounted soap dispensers by the common area sinks. Employee A reported no knowledge of soap or any other chemicals being left out in the memory care unit.

On 6/2/2026, Employee B's statement was consistent with Employee A's statement.

On 6/2/2026, due to this special investigation, I completed an inspection of the memory care unit and observed the wall mounted soap dispensers in the memory care kitchenette. No individual soap bottles were observed in the memory care unit. However, during the inspection, diffuser oils were found unsecured in the memory care unit kitchenette cabinet and knives were found unsecured in a kitchenette drawer.

**Please note that this is a repeat violation from the facility survey inspection that was completed on 2/10/2026, in which hazardous and toxic chemicals were found unsecured under the sink and in an unlocked wall closet in the memory care unit.

APPLICABLE RULE	
R 325.1979	**General maintenance and storage.**
	(3) Hazardous and toxic materials shall be stored in a safe manner.

ANALYSIS:	It was alleged that chemicals such as soap are not stored safely in the memory care unit. Interviews and onsite investigation revealed that while there was no soap found left out in the memory care unit, hazardous and toxic chemicals and sharps were found easily accessible to anyone in the facility, and this presents a potential risk of ingestion, harm, and/or injury to residents in the home with impaired cognition and/or function. Therefore, the facility is in violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an approved correction action plan, I recommend the status of this license remains the same.

Julie Viviano

6/9/2026

_____

Julie Viviano Date
Licensing Staff

Approved By:

Andrea L Moore

07/30/2026

_____

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