RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

November 30, 2017

Lauren Reenders
Seminole Shores Assisted Living Center
850 Seminole Road
Muskegon, MI 49441-3430

RE: License #: AH610255010
Investigation #: **2018A0784005**
Seminole Shores Assisted Living Center

Dear Ms. Reenders:

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.

Sincerely,

Aaron L Clum

Aaron Clum, Licensing Staff
Bureau of Community and Health Systems
4809 Clio Road
Flint, MI 48504
(517) 230-2778

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

I. IDENTIFYING INFORMATION

License #:	AH610255010
Investigation #:	2018A0784005
Complaint Receipt Date:	06/30/2017
Investigation Initiation Date:	06/30/2017
Report Due Date:	08/29/2017
Licensee Name:	Seminole Shores Operating Company
Licensee Address:	950 Taylor Avenue Grand Haven, MI 49417
Licensee Telephone #:	(616) 842-2425
Administrator:	Judith Delis
Authorized Representative:	Lauren Reenders
Name of Facility:	Seminole Shores Assisted Living Center
Facility Address:	850 Seminole Road Muskegon, MI 49441-3430
Facility Telephone #:	(231) 780-2944
Original Issuance Date:	07/24/2003
License Status:	REGULAR
Effective Date:	06/11/2017
Expiration Date:	06/10/2018
Capacity:	129
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
A resident that required staff assistance with transfers independently and without staff knowledge went to the bathroom, fell, and suffered harm.	Yes
Additional Findings	Yes

III. METHODOLOGY

06/30/2017	Special Investigation Intake 2018A0784005
06/30/2017	Special Investigation Initiated – Document Review Completed review of documents provided by the facility.
07/06/2017	Inspection Completed On-site Interviews conducted with Resident Services Coordinator Mary Bentley and Administrator Judi Delis. Facility observations made.
08/04/2017	Contact - Telephone call made Telephone interview conducted with Resident Support Aide Odell Taylor
08/04/2017	Contact - Telephone call made Telephone contact attempted with Resident Support Aide Trainee Tango Cunningham. Message left requesting a return call.
08/04/2017	Contact - Telephone call made Telephone contact attempted with Shift Supervisor Donna Hussey. Message left requesting a return call.
08/04/2017	Contact - Telephone call made Telephone contact attempted with Shift Supervisor Claudia Buehrle. Message left requesting a return call.

11/29/2017	Exit Conference Telephone contact made with Authorized Representative Lauren Reenders.

ALLEGATION:

A resident that required staff assistance with transfers independently and without staff knowledge went to the bathroom, fell, and suffered harm.

INVESTIGATION:

On 4/19/17, the department received an incident report explaining that on 4/16/17, Resident A was found bleeding from the head on her bathroom floor and later passed away at the hospital.

On 6/30/17, I reviewed Resident A's service plan and staff.

Resident A's service plan indicated that Resident A needed one person to assist her with transfer from bed to wheelchair, wheelchair to bed and when using the restroom. The plan further indicates Resident A was capable of using a call light when needing assistance and used an alarm mat for safety. The plan also read Resident A was showing no behavioral concerns and was alert to person, place, and time.
Staff notes, written by supervisor Donna Hussey, indicate that Ms. Hussey spoke with Resident A prior to Resident A's bedtime. It was noted that Resident A told Ms. Hussey she wanted to finish reading and would use her call light for assistance prior to going to bed. Ms. Hussey did not note a time in this entry. Ms. Hussey did make a "late entry" dated 5/12/17, stating that on 4/16/17 she checked on Resident A at 8:45 pm and witnessed the call light in her lap. Staff member Tango Cunningham made a late entry dated 5/12/17 indicating she last checked on Resident A at 7:30 pm.

Supervisor Claudia Buehrle documented that at 11:15 pm, Resident A was found lying on her left side in front of her bathroom toilet. Similar to Ms. Hussey and Ms. Cunningham, Ms. Buehrle entered a "late entry" on 5/8/17 that indicated at 11:20 pm she heard an alarm sounding in Resident A's room. Ms. Buehrle further noted that upon hearing the alarm, she entered Resident A's room and noticed Resident A's call light cord lying in a recliner in the room and that she found Resident A lying on the floor in her bathroom next to a large amount of blood.

On 7/6/17, I reviewed the staff work schedule at the facility. The schedule for 4/16 revealed Ms. Cunningham was receiving on the job training provided by staff member Odell Taylor.

On 7/6/17, I interviewed Resident Services Coordinator Mary Bently at the facility. Ms. Bently confirmed that Resident A did have a call light which was meant to be

used by her when assistance was needed. Ms. Bently stated Resident A would frequently not use her call light for assistance and that staff were aware of this. She stated Resident A also had a pressure sensitive alarm mat for her chair designed to notify staff when Resident A left the chair. Ms. Bently stated Resident A had had frequent falls when she first came to the facility in 2013. She stated Resident A had not used her call light “in a long time”. She stated Resident A’s falls had been infrequent and sporadic. Ms. Bently stated she was not present on 4/16/17 when Resident A fell and was told by staff that Resident A was last checked on at 10 pm that evening.

Ms. Bently stated that although Resident A would not use her call light, no other measures had been taken, regarding Resident A’s potential fall risk, other than the alarm mats which had been placed by her bed and on her wheelchair.

On 7/6/17, I interviewed Administrator Judi Delis at the facility. Ms. Delis statements coincided with those made by Ms. Bently. She stated Resident A “was known to undress herself” without calling for assistance. Ms. Delis stated Resident A had a mat alarm on the floor next to her bed as well and a mat alarm on her wheelchair. She stated the alarm sounds from a box connected to the mat and located inside the resident’s room. Ms. Delis stated she was instructed by the Fire Marshall to keep Resident doors closed for fire safety reasons. Ms. Delis stated the alarm may have been harder for staff to hear because Resident A had her door shut on the evening of the fall.

Ms. Bently and I observed a chair mat alarm box located in a resident’s room. While the alarm sounded, and with the resident’s door closed, I slowly walked away from the room. I found it difficult to hear the alarm one room down. After reaching the second room down the hall, the alarm was barely heard. It should be noted that the hallway was empty and very quiet at that time.

On 8/4/17, I interviewed Resident Aid Odell Taylor by telephone. Mr. Taylor stated he was not working directly with Resident A on the evening of 4/16/17. Mr. Taylor stated that he believed Ms. Cunningham last checked on Resident A around 9pm that evening. Mr. Taylor stated Resident A had fallen at least once during a shift he was working “about a month prior” to 4/16/17. He stated that in the weeks prior to 4/16/17, Resident A frequently did not use her call light for assistance, was attempting to dress herself without assistance on a regular basis and was attempting to get out of her wheelchair more frequently without assistance. Mr. Taylor stated he spoke with Ms. Hussey “about a month” prior to 4/16/17 about Resident A’s changing behavior and that Ms. Hussey told staff to check on Resident A every two hours.

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents;**
	(1) A health facility or agency that provides services directly to patients or residents and is licensed under this article shall adopt a policy describing the rights and responsibilities of patients or residents admitted to the health facility or agency. Except for a licensed health maintenance organization which shall comply with chapter 35 of the insurance code of 1956, 1956 PA 218, MCL 500.3501 to 500.3580, the policy shall be posted at a public place in the health facility or agency and shall be provided to each member of the health facility or agency staff. Patients or residents shall be treated in accordance with the policy.
For Reference: MCL 333.20201	**2(e) A patient or resident is entitled to receive adequate and appropriate care, and to receive, from the appropriate individual within the health facility or agency, information about his or her medical condition, proposed course of treatment, and prospects for recovery, in terms that the patient or resident can understand, unless medically contraindicated as documented in the medical record by the attending physician or a physician's assistant to whom the physician has delegated the performance of medical care services.**

ANALYSIS:	Resident A had a history of falling and required the assistance of one staff member for transfers. Review of Resident A's service plan revealed that staff were to assist with transfers and that a call light along with a floor and chair alarming mat were additional methods to ensure staff would know she needed assistance. Interviews with staff combined with staff notes reviewed reveal Resident A had not utilized the call light system to summon assistance for a long period of time. It is not known whether this was due to changes in her competency or her personal preference. In addition, reliance of an assistive sounding device that cannot be heard when a door is closed seems ineffective as a method for staff to know when help is needed. The plan developed to ensure proper supervision and protection from harm was not adequate nor appropriate to prevent a resident with a history of falling from suffering harm.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

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.
For Reference: R 325.1901	**Definitions.**
	(21) "Service plan" means a written statement prepared by the home in cooperation with a resident and/or the resident's authorized representative or agency responsible for a resident's placement, if any, and that identifies the specific care and maintenance, services, and resident activities appropriate for each individual resident's physical, social, and behavioral needs and well-being and the methods of providing the care and services while taking into account the preferences and competency of the resident.

ANALYSIS:	It is unknown for sure why Resident A did not use her call light. Resident A's service plan was not updated to reflect that though she could use the call light she did not and required staff to monitor her for assistance.
CONCLUSION:	**VIOLATION ESTABLISHED**

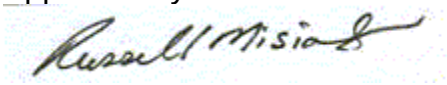
IV. RECOMMENDATION

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

11/29/2017

Aaron Clum — Date
Licensing Staff

Approved By:



11/29/17

Russell B. Misiak — Date
Area Manager