GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 18, 2024

Lauren Gowman
Railside Assisted Living Center
7955 Byron Center Ave SW
Byron Center, MI 49315

RE: License #: AH410236873
Railside Assisted Living Center
7955 Byron Center Ave SW
Byron Center, MI 49315

Dear Lauren Gowman:

Attached is the Renewal Licensing Study Report for the facility referenced above. The violations cited in the report require the submission of a written corrective action plan. 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 dates 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 licensee or licensee designee or home for the aged authorized representative and a date.

Upon receipt of an acceptable corrective action plan, a regular license will be issued. If you fail to submit an acceptable corrective action plan, disciplinary action will result. 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 feel free to contact the local office at (517) 284-9730.

Sincerely,

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
RENEWAL INSPECTION REPORT

I. IDENTIFYING INFORMATION

License #:	AH410236873
Licensee Name:	Railside Living Center LLC
Licensee Address:	950 Taylor Street Grand Haven, MI 49417
Licensee Telephone #:	(616) 842-2425
Authorized Representative:	Lauren Gowman
Administrator/Licensee Designee:	Shannon Del Raso
Name of Facility:	Railside Assisted Living Center
Facility Address:	7955 Byron Center Ave SW Byron Center, MI 49315
Facility Telephone #:	(616) 878-4620
Original Issuance Date:	04/18/1999
Capacity:	121
Program Type:	ALZHEIMERS AGED

II. METHODS OF INSPECTION

Date of On-site Inspection(s): 12/17/2024

Date of Bureau of Fire Services Inspection if applicable: 5/1/2024; BFS - C

Inspection Type: ☐Interview and Observation ☒Worksheet ☐Combination

Date of Exit Conference: 12/17/2027

No. of staff interviewed and/or observed 15
No. of residents interviewed and/or observed 42
No. of others interviewed 0 Role N/A

- Medication pass / simulated pass observed? Yes ☒ No ☐ If no, explain.

- Medication(s) and medication records(s) reviewed? Yes ☒ No ☐ If no, explain.
- Resident funds and associated documents reviewed for at least one resident? Yes ☐ No ☒ If no, explain. The home does not keep resident funds in trust.
- Meal preparation / service observed? Yes ☒ No ☐ If no, explain.

- Fire drills reviewed? Yes ☐ No ☒ If no, explain.
  Reviewed disaster plans along with interviewed staff on policies and procedures.
- Water temperatures checked? Yes ☒ No ☐ If no, explain.

- Incident report follow-up? Yes ☐ IR date/s: N/A ☒
- Corrective action plan compliance verified? Yes ☐ CAP date/s and rule/s: N/A
- Number of excluded employees followed up? 0 N/A ☒

III. DESCRIPTION OF FINDINGS & CONCLUSIONS

This facility was found to be in non-compliance with the following rules:

R 325.1922	**Admission and retention of residents.**
	(7) An individual admitted to residence in the home shall have evidence of tuberculosis screening on record in the home that was performed within 12 months before admission. Initial screening may consist of an intradermal skin test, a blood test, a chest x-ray, or other methods recommended by the public health authority.
ANALYSIS:	Review of eight resident files revealed a TB screen for Resident A had not been completed prior to admission on 11/8/2024. A TB screen must be completed within 12 months before admission**.**
CONCLUSION:	**VIOLATION ESTABLISHED**

R 325.1932	**Resident medications.**
	(2) The giving, taking, or applying of prescription medications shall be supervised by the home in accordance with the resident's service plan.
ANALYSIS:	During review of Resident B's medication administration record, it was revealed Resident B was administered medication in applesauce, but the physician orders indicate medications are to be administered with water not applesauce. Medication is to be given, taken, or applied in accordance with physician orders.
CONCLUSION:	**VIOLATION ESTABLISHED**

R 325.1975	**Laundry and linen requirements.**
	(1) A new construction, addition, major building change, or conversion after November 14, 1969 shall provide all of the following: **(b) A separate clean linen storage room.**

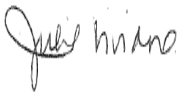
ANALYSIS:	Inspection revealed items such as a step stool, housekeeping cart, Hoyer device sling, container of personal protection equipment, and two crates of miscellaneous items were stored with the clean linens. This poses a risk for cross contamination. Clean linens must be stored separate of all other items in the clean linen storage area/room.
CONCLUSION:	**VIOLATION ESTABLISHED**

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:	On-site inspection revealed multiple food items were found unlabeled in common area kitchenettes and the main service kitchen cold and dry food storage areas. These items were not labeled with the appropriate open date, and it could not be determined if the food items were safe for human consumption. An open date must be placed on all food items in the facility once opened.
CONCLUSION:	**VIOLATION ESTABLISHED**

R 325.1979	**General maintenance and storage.**
	(3) Hazardous and toxic materials shall be stored in a safe manner.
ANALYSIS:	Inspection revealed hazardous and toxic chemicals, and a sharp pair of scissors were stored in a cabinet and a drawer in the common dining room. The items were 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.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Receipt of an acceptable corrective action plan is requested for the above deficiencies.



12/18/2024

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Date

Licensing Consultant