GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 27, 2024

Lisa Sikes
Norton Shores Care Operations, LLC
1435 COIT AVE. NE
GRAND RAPIDS, MI 49505

RE: License #: AL610418574
Investigation #: 2025A0357004
Harbor Homes Assisted Living 1

Dear Ms. Sikes:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

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 (616) 356-0100.

Sincerely,

Arlene B. Smith

Arlene B. Smith, MSW, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 916-4213

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL610418574
Investigation #:	2025A0357004
Complaint Receipt Date:	10/31/2024
Investigation Initiation Date:	10/31/2024
Report Due Date:	12/30/2024
Licensee Name:	Norton Shores Care Operations, LLC
Licensee Address:	1435 Coit Ave. NE, Grand Rapids, MI 49505
Licensee Telephone #:	(231) 600-7188
Administrator:	Lisa Sikes
Licensee Designee:	Christina Barton
Name of Facility:	Harbor Homes Assisted Living 1
Facility Address:	2649-A Vulcan St., Norton Shores, MI 49444
Facility Telephone #:	(231) 600-7188
Original Issuance Date:	08/14/2024
License Status:	TEMPORARY
Effective Date:	08/14/2024
Expiration Date:	02/13/2025
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL, AGED

II. ALLEGATION(S)

	Violation Established?
On 10/19/2024, Resident A was transferred to another room by the use of a bedsheet.	No

III. METHODOLOGY

10/31/2024	Special Investigation Intake 2025A0357004 Department of Health and Human Services, Kent County, Adult Protective Services denied the referral.
10/31/2024	Special Investigation Initiated - Telephone
12/26/2024	Inspection Completed On-site Unannounced inspection
12/26/2024	Contact - Face to Face Interview with Candy Bitson, LPN, Wellness Director.
12/26/2024	Contact - Document Received Reviewed Resident A's file, received copy of Assessment Plan and Interim Health Care Hospice note dated 10/18/2024.
12/27/2024	Contact - Telephone call made to Administrator Chris Barton to discuss the complaint
12/27/2024	Telephone exit conference with the Licensee Designee.

ALLEGATION: On 10/19/2024, Resident A transferred to another room by the use of a bed sheet.

INVESTIGATION: On 12/26/204, I made an unannounced inspection of the facility. I conducted a face-to-face interview with Candy Bitson, LPN, Wellness Director. She reported that Resident A was admitted to the facility on 06/23/2024. She explained that Resident A had heart trouble, diabetes, and an unusual type of seizures where she would just be unresponsive. Resident A had gone to the hospital many times so the family decided to put her on Hospice, date unknown. She explained that Resident A was receiving Hospice care from Interim Health Care Hospice. She provided me with a copy of the Interim note dated 10/18/2024that read: “Unresponsive to verbal and tactile stimuli, All PO meds d/c unable to swallow. Comfort meds (listed), D/C blood sugar checks, will see daily”. Ms. Bitson stated that on 10/19/2024, Resident A was “actively dyeing”. Her respirations were at 40 and

she was receiving Morphine. She reported that the direct care staff had called her at home around 9:00PM and asked her to come in to see Resident A. She came in and found Resident A restless and appearing in pain. She stated that she called Hospice, and they prescribed 0.5ML of morphine, so Ms. Bitson administered the medication around 9:28 PM. She reported that the Hospice nurse was on her way. She went on to describe that Resident A shared a room with a resident who had dementia and was constantly yelling, screaming and carrying on with verbal outburst. They removed her from the room, but she just kept returning to her side of the room. Resident A's daughter requested that they wanted their mother to die in peace, so they requested she be moved right next door because the room was empty. They tried to move her bed out of the room, but it would not fit, and it would have taken a long time to take the bed apart. She said she and the Administrator, Christine Barton, decided to move Resident A by her bedsheet. Ms. Bitson said this was not against their policy. She explained that Resident A's daughter was present so she explained to her how they could move her by her bedsheet and Ms. Bitson would be helping carry her and she would also be holding her head. She reported that Resident A was very small and weighed very little. She reported that she was safely transferred to the room and bed next door. She said they had many pillows under her and she relaxed once in the new bed. She thought they moved her around 10:25 PM. She stated the family members were relieved and thankful. She was uncertain to the time of death but thought it was around 11:00PM just after the Hospice nurse had arrived. Ms. Bitson stated that the family was very appreciative and have been back in to thank everyone.

On 12/27/2024, I spoke by telephone with the Administrator, Christine Barton and she reported that she approved the LPN, Ms. Bitson, moving Resident A by the sheet to the empty room next door. She said that Resident A's family could then be alone with Resident A and it would be peaceful for all of them.

On 12/27/2024, I spoke with Resident A's daughter, and she reported that she asked for her mother to be moved due to the roommate's outburst. She said four to five staff helped move her along with herself and it was done with dignity, and it was best for her mother and the family members. She thought that the roommate needed her privacy as well. She reported that her mother weighed less than 100 pounds. She said her mother was well cared for. She reported that Resident A passed at 10:55 PM and the Hospice nurse came around midnight.

On 12/27/2024 I conducted a telephone exit conference with the Licensee Designee, Lisa Sikes and she agreed with my findings.

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:	On 10/19/2024, Resident A transferred to another room by the use of a bed sheet. Resident A's daughter asked that Resident A be moved to another room when she was actively dyeing because her roommate was yelling and screaming at the time, and she wanted her mother to die in peace. She acknowledged that they did move her with a bedsheet with herself, Ms. Bitson, LPN and four to five staff and she reported her mother was treated with dignity and she die well once she was moved. Ms. Bitson, LPN and the Administrator Ms. Barton agreed to move Resident A by a bedsheet because the bed would not fit through the door. During this investigation there was no evidence found that Resident was not treated with dignity and respect. Therefor there is no violation to the rule.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

I recommend the compliant be closed and the license remain the same.

Arlene B. Smith 12/27/2024

Arlene B. Smith Date
Licensing Consultant

Approved By:

Jerry Hendrick 12/27/2024

Jerry Hendrick Date
Area Manager