



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 22, 2025

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

RE: License #: AH610255010
Investigation #: 2026A1010006
Seminole Shores Assisted Living Center

Dear Licensee:

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 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 (877) 458-2757.

Sincerely,

A handwritten signature in blue ink that reads "Lauren Wohlfert".

Lauren Wohlfert, Licensing Staff
Bureau of Community and Health Systems
350 Ottawa NW Unit 13 7th Floor
Grand Rapids, MI 49503
(616) 260-7781
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH610255010
Investigation #:	2026A1010006
Complaint Receipt Date:	10/29/2025
Investigation Initiation Date:	10/30/2025
Report Due Date:	12/28/2025
Licensee Name:	Seminole Shores Operating Company
Licensee Address:	950 Taylor Avenue Grand Haven, MI 49417
Licensee Telephone #:	(616) 842-2425
Administrator:	Mallory Hollomon
Authorized Representative:	Lauren Gowman
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:	08/01/2025
Expiration Date:	07/31/2026
Capacity:	129
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A fell in his room and was injured on 10/11/2025. Staff did not check on Resident A for several hours and were therefore not aware he was injured.	Yes
Additional Finding	Yes

III. METHODOLOGY

10/29/2025	Special Investigation Intake 2026A1010006
10/30/2025	Special Investigation Initiated - Letter APS referral made with Centralized Intake
10/30/2025	APS Referral APS referral made with Centralized Intake
11/06/2025	Inspection Completed On-site
11/06/2025	Contact - Document Received Received resident service plan and incident report
11/07/2025	Contact - Document Received Received resident internal investigation documents via email from the administrator
12/22/2025	Exit Conference

ALLEGATION:

Resident A fell in his room and was injured on 10/11/2025. Staff did not check on Resident A for several hours and were therefore not aware he was injured.

INVESTIGATION:

On 10/29/2025, the Bureau received the complaint. The allegations read Resident A was “wondering around have being [sic] given adivan [sic]. He was checked on at 8:30 and then was found in the afternoon 12:05 in his bathroom surrounded by blood and had a wound on his head. The resident was not given his medication on time and nobody noticed when he didn’t show up for breakfast or lunch.”

On 10/30/2025, I made an Adult Protective Services (APS) referral with Centralized Intake.

On 11/06/2025, I interviewed Staff Person 1 (SP1) at the facility. SP1 reported that on 10/11/2025, Resident A fell in the bathroom in his room. SP1 stated she was not present in the building when the incident occurred. SP1 said she was notified by telephone of the incident.

SP1 explained SP2 went into Resident A's room to cue him to go to the dining room for the lunch time meal. SP1 reported SP2 observed Resident A in his room with blood "all over" while he was sitting in his recliner chair. SP1 stated SP2 observed blood in Resident A's bathroom. SP1 said it appeared Resident A fell in his bathroom, however he was able to get himself up and into his recliner chair. SP1 reported Resident A resides in the facility's secured memory care unit and is unable to make his needs known.

SP1 stated Resident A is currently receiving hospice services through Gentiva Hospice. SP1 reported staff contacted Gentiva Hospice after Resident A was observed injured in his room. SP1 explained Witness 1 (W1) arrived at the facility to assess resident A shortly after staff contacted her. SP1 said Resident A took pictures of Resident A's injuries and sent them to Resident A's hospice physician. SP1 stated Resident A's Gentiva Hospice staff determined Resident A did not need to be transported to the hospital for evaluation and treatment. SP1 explained W1 treated Resident A's wounds at the facility using steri-strips.

SP1 reported Resident A's fall was unwitnessed, therefore the exact time the incident occurred is unknown. SP1 said the facility's administrator completed an internal investigation to determine the timeframe of when staff observed Resident A and were in his room. SP1 stated the administrator observed video footage to determine the timeframe of the incident on 10/11/2025. SP1 said staff completed an incident report on 10/11/2025.

SP1 provided me with a copy of Resident A's incident report. The *Briefly Describe What Occurred* section of the report read, "[SP2] entered this resident's room to assist resident to lunch. It was noted that a large amount of blood was on bathroom floor, sink and walls. Resident was observed sitting in recliner with blood on his upper body coming from left side and top of his head. [SP3] and [S4] were called to room. Resident was cleaned up by staff without causing further pain and was noted to have a laceration on top of head and large open wound to left side of head. Noted to have small skin tear on left elbow. Upon assessment, resident denied any pain and was alert and oriented at baseline. Resident denied dizziness and was able to follow commands with range of motion at baseline. Bleeding was controlled and staff held pressure to wound. Gentiva Hospice nurse was requested immediately at 12:10 PM. [W1] arrived at 1:01 PM and provided wound care. Resident unable to provide details of fall due to cognition. Intervention: Request POA sign for motion alarm."

The *Resident Statement* section of the report read, "I fell twice." The report was dated 10/11/2025 at 12:05 PM.

SP1 reported Resident A ambulates around the memory care unit independently without the use of an assistive device. SP1 stated Resident A often "paces" around the unit and attempts to enter other resident rooms. SP1 said Resident A has a history of displaying verbal aggression and agitation. SP1 explained Resident A is prescribed medications to address agitation. SP1 reported staff administered Resident A's prescribed Ativan at 4:17 pm on 10/10/2025 and at 12:17 am and 7:30 pm on 10/11/2025 due to agitation that he exhibited.

SP1 stated Resident A is independent with toileting and dressing himself. SP1 reported Resident A is visually impaired, however he can complete most of his activities of daily living (ADLs) independently. SP1 said Resident A is often out of his room walking around the unit during the day. SP1 reported that as a result, staff can adequately supervise him.

SP1 provided me with a copy of Resident A's service plan for my review. The *BEHAVIORS* section of the plan read, "Directions: Intervene as follows to address the inappropriate behaviors: Fi [sic] resident is yelling for his wife or fixating on leaving. Offer him food or drink. Hand him things to hold just [sic] as books and soft pipes. Current status: Exit seeking, will stand by the door to be let out. Please chart resident's behavior ie; pacing, exit seeking, obsessive, aggressive." The *TOILETING* section of the plan read, "Current Status: Independent, no assistance required. Resident's Desired Goals & Outcomes: Maintain independence. Ongoing assessment from staff that resident maintains current status."

The *VISUAL CHECKS* section of the plan read, "Schedule: Daily@ 12:00 PM, 4:00 PM, 6:00 PM, 8:00 PM, 10:00 PM, 8:00 AM, 10:00 AM, As Needed." The *HIGHER FALL RISK* section of the plan read, "Directions: I am at a higher risk for falling based on: a. legally blind b. dementia c. depression Please take the following interventions to reduce my risk for falling a. provide positive reassurance and guidance to activities b. do not re-arrange furniture c. encourage him to use his walking stick d. Ask [Relative A1] to bring in a pair of grip slippers for the resident e. intervention: 6/19/23 Request a med review f. Intervention 1/11/24 – Request family supply depends products g. Intervention 2/26/24 Request med review due to increased behaviors h. Intervention 4/1/24 Increase visual checks i. Intervention 8/7/24 Do not allow resident to get his own coffee J. Intervention 3/14/25 Add visual checks in the Evening k. Intervention 4/24/25 Added visual checks to the Day time l. Intervention 5/2/25 Requested med review m. Intervention 8/18/25 supervised toileting to every 2 hours n. Intervention 10/11/25 Request [Relative A1] sign for motion alarm."

On 11/06/2025, I interviewed SP5 at the facility. SP5 stated she was at the facility when the incident occurred on 10/11/2025. SP5 reported she was not scheduled in the facility's secured memory care unit; however she heard the responding staff

summon her for assistance on the two-way radio on her person. Resident A's statements regarding the incident were consistent with SP1. SP5's statements regarding Resident A's care needs were consistent with Resident A's service plan.

On 11/06/2025, I interviewed W1 at the facility. W1's statements were consistent with SP1 and Resident A's incident report that was dated 10/11/2025. W1 reported she was able to effectively treat and dress the wounds on Resident A's head at the facility.

On 11/06/2025, I attempted to interview Resident A at the facility. I was unable to engage Resident A in meaningful conversation.

On 11/07/2025, I received an email from the administrator. The administrator provided me with copies of her internal investigation documents for my review. The *Summary of Findings* section of the *Internal Investigation Worksheet* document read, "In following this investigation, Resident was last seen on camera at 12:30am on 10/10/2025 and was not observed on the cameras or documented on for supervision checks until 8am. Supervision check for 8am was not documented on but was observed on the cameras by Administrator being completed by employees [SP2 and SP3] on 10/11/2025 at 8:32:55am and walked out at 8:33:05am. Furthermore, this means the Resident was left unattended from 8:32am until 12:05pm when Employee [SP2] observed the Resident in his recliner at the time of the incident. Meaning, the scheduled supervision check at 10am was not completed. This also means that the Resident was never brought down to breakfast by staff the morning of 10/11/2025.

The findings of this investigation also reflect that the [Resident A] was not given his scheduled 8am medications. The employee [SP3] passed the Residents 8am medications at 10:38am in ECP. However, Administrator reviewed the cameras and did not observe the employee [SP3] passing medications as she did not enter the Residents apartment during the hours of 7a, 8a, 9am, 10am or 11am. However, the employee [SP3] did enter the Residents apartment at 8:32:55am and walked out at 8:33:05am to complete the scheduled 8am supervision check. However, upon interviewing this employee [SP3] she acknowledged that this is not when the medication was passed, that it was earlier. Administrator again, did not observe employee [SP3] on the cameras to enter the apartment any other time during the hours of 7a-11a."

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:	The review of Resident A's service plan, along with review of the facility's <i>Internal Investigation Worksheet</i> document, revealed staff did not complete a visual check on Resident A between the hours 8:32 am and 12:05 pm on 10/11/2025. Resident A's service plan read staff are to observe Resident A daily at 8:00 am, 10:00 am, and 12:00 pm. Staff did not complete the required visual checks on Resident A on 10/11/2025, therefore the facility was not in compliance with this rule.
CONCLUSION:	VIOLATION ESTABLISHED

ADDITIONAL FINDING:

INVESTIGATION:

Review of the *Internal Investigation Worksheet* document read Resident A was not offered breakfast on 10/11/2025. Resident A relies on staff assistance to cue him to walk to the dining room for meals. Staff did not complete this task, therefore Resident A missed the breakfast meal.

APPLICABLE RULE	
R 325.1952	Meals and special diets.
	(1) A home shall offer 3 meals daily to be served to a resident at regular meal times. A home shall make snacks and beverages available to residents.
ANALYSIS:	Review of the <i>Internal Investigation Worksheet</i> document read staff did not cue Resident A to go to the dining room for breakfast on 10/11/2025. As a result, Resident A did not receive breakfast on 10/11/2025. The facility was not in compliance with this rule.
CONCLUSION:	VIOLATION ESTABLISHED

I shared the findings of this report with the facility's licensee authorized representative on 12/22/2025.

IV. RECOMMENDATION

I recommend the status of the license remains unchanged.

Lauren Wohlfert

12/05/2025

Lauren Wohlfert
Licensing Staff

Date

Approved By:

Andrea Moore

12/22/2025

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

Date