STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

GRETCHEN WHITMER
GOVERNOR

MARLON I. BROWN, DPA
DIRECTOR

September 30, 2025

Joshua Simmer
Northcrest Assisted Living Community
2650 Ruddiman Street
North Muskegon, MI 49445

RE: License #: AH610236856
Investigation #: 2025A0627006
Northcrest Assisted Living Community

Dear Joshua Simmer:

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 (517) 335-5985.

Sincerely,

Rick Brummette, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

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

## I. IDENTIFYING INFORMATION

| | |
|---|---|
| **License #:** | AH610236856 |
| | |
| **Investigation #:** | 2025A0627006 |
| | |
| **Complaint Receipt Date:** | 07/30/2025 |
| | |
| **Investigation Initiation Date:** | 08/08/2025 |
| | |
| **Report Due Date:** | 09/29/2025 |
| | |
| **Licensee Name:** | Northcrest Operating Company |
| | |
| **Licensee Address:** | 2650 Ruddiman Dr<br>Muskegon, MI 49445 |
| | |
| **Licensee Telephone #:** | 231-744-2447 |
| | |
| **Administrator:** | Joshua Simmer, Administrator |
| | |
| **Authorized Representative/** | Joshua Simmer, Authorized Rep. |
| | |
| **Name of Facility:** | Northcrest Assisted Living Community |
| | |
| **Facility Address:** | 2650 Ruddiman Street<br>North Muskegon, MI 49445 |
| | |
| **Facility Telephone #:** | (231) 744-2447 |
| | |
| **Original Issuance Date:** | 06/01/1976 |
| | |
| **License Status:** | REGULAR |
| | |
| **Effective Date:** | 08/01/2025 |
| | |
| **Expiration Date:** | 07/31/2026 |
| | |
| **Capacity:** | 86 |
| | |
| **Program Type:** | AGED<br>ALZHEIMERS |

## II. ALLEGATION(S)

| | Violation Established? |
|---|---|
| Resident A was left in excrement resulting in skin breakdown. | No |
| Staff often ignore resident call lights in the rest of the facility. | No |
| Additional Findings | No |

## III. METHODOLOGY

| | |
|---|---|
| 07/30/2025 | Special Investigation Intake<br>2025A0627006 |
| 07/30/2025 | APS Referral |
| 08/08/2025 | Contact - Face to Face |
| | |

**ALLEGATION:**

**Resident A was left in excrement resulting in skin breakdown.**

**INVESTIGATION:**

On 07/31/2025, the licensing department received a complaint with allegations that Resident A had an incontinent episode and was left in feces.

On 08/08/2025, I interviewed Administrator Josh Simmer and Staff Person 2 (SP2) at the facility who reported they had received a complaint of a similar nature for Resident A. SP2 reported that Resident A does refuse care at times, refuses to get out of bed often, is selective about what care givers Resident A will allow to provide care, and then speaks harshly and demandingly to staff while receiving care. SP2 reported Resident A has been receiving hospice services since June 2025 and hospice performs twice weekly dressing changes to Resident A's buttocks that started on July 26, 2025, and that facility staff perform dressing changes between hospice visits, as needed.

I reviewed Hospice documentation that revealed Resident A did have dressing changes ordered twice weekly for right and left buttock pressure ulcers.

On 08/08/2025, I interviewed Resident A at the facility. Resident A reported that the facility provides good care and answers the call light when Resident A needs help. Resident A denied being left in urine or feces for excessive amounts of time.

On 08/08/2025 I interviewed SP3 at the facility. SP3 reported that Resident A could be difficult sometimes but could also be very "sweet" and that Resident A had yelled at her for not laying Resident A's bed down flat after a care encounter that morning. SP3 was unaware of any instances where Resident A's dressing needed to be changed by facility staff.

On 08/08/2025 I reviewed Resident A's service plan in which direction was found indicating that Hospice changes the dressings on Mondays and Thursdays to the left lower buttocks and on the right buttocks with facility staff changing dressings "as necessary." The specific directions included: "*Wound care to left lower buttocks stage II pressure ulcer, cleanse with wound cleanser and pat dry with gauze, cover with foam cleanser dressing…..as needed by staff." And "Gently cleanse wound on RT buttocks, pat dry with clean gauze, cover with foam dressing…..(as necessary) when dressing is soiled and/or dislodged."*

| **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:** | Based on interviews, document review, and direct observation there was no evidence that the allegation had occurred. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

**ALLEGATION:**

**Staff often ignore resident call lights in the rest of the facility.**

**INVESTIGATION:**

On 08/08/2025 I interviewed the administrator and SP2 regarding whether they receive complaints that call lights are not being answered timely. Both reported that they have not had any complaints regarding excessive wait times and credit that to

the call light system being monitored and prompt communication by walkie talkie from the monitoring station when a call light is on too long.

I reviewed the facility's Incident Report log and it did not highlight any issues related to call lights.

SP3 reported she was unaware of any problems with residents in the facility having excessive wait times for call lights to be answered.

I interviewed a sample of residents in the facility regarding excessive call light wait times and what they thought of the care they were receiving.

On 08/08/2025, I interviewed Resident B at the facility. Resident B reported getting good care here and has not experienced excessive wait times for the call light to be answered.

On 08/08/2025, I interviewed Resident C at the facility. Resident C reported that the rooms are a little small for 2 residents to live in but denied that call lights were not answered timely.

On 08/08/2025, I interviewed Resident D at the facility. Resident D reported that he had no complaints about call lights not being answered but found the food to be "kind of different."

On 08/08/2025, I interviewed Resident E at the facility. Resident E reported that the care is good but had no issues with the call light being answered promptly.

Resident A also stated that the facility provides good care and does not have to wait too long for the call light to be answered.

| **APPLICABLE RULE** | |
|---|---|
| **R 325.1931** | **Employees; general provisions.** |
| | **(4) The supervisor of resident care on each shift shall do all of the following:**<br>**(a) Assure that residents are treated with kindness and respect.**<br>**(b) Protect residents from accidents and injuries.** |
| **ANALYSIS:** | Interview and observation noted no evidence to support the allegation. |
| **CONCLUSION:** | **VIOLATION NOT ESTABLISHED** |

## IV. RECOMMENDATION

I recommend no change in the status of the license.

08/29/2025

Rick Brummette — Date
Licensing Staff

Approved By:

09/30/2025

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