GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 20, 2022

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

RE: License #:	AH610255010
Investigation #:	2022A1021059
	Seminole Shores Assisted Living Center

Dear Mrs. Gowman:

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) 284-9730

Sincerely,

Kimberly Horst, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
Lansing, MI 48909

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH610255010
Investigation #:	2022A1021059
Complaint Receipt Date:	09/06/2022
Investigation Initiation Date:	09/07/2022
Report Due Date:	11/06/2022
Licensee Name:	Seminole Shores Operating Company
Licensee Address:	950 Taylor Avenue Grand Haven, MI 49417
Licensee Telephone #:	(616) 842-2425
Administrator:	Kurt Sapp
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:	06/11/2021
Expiration Date:	06/10/2022
Capacity:	129
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Facility has had increase Covid-19 cases.	No
Residents personal care needs are not met.	No
Employees speak rudely about residents.	No
Facility has insufficient staff.	No
Facility has an odor.	No
Additional Findings	No

III. METHODOLOGY

09/06/2022	Special Investigation Intake 2022A1021059
09/07/2022	Special Investigation Initiated - Letter referral sent to APS
09/19/2022	Inspection Completed On-site
09/20/2022	Contact-Documents Received Received training documents
	Exit Conference

ALLEGATION:

Facility has had increase in Covid-19 cases.

INVESTIGATION:

On 9/6/22, the licensing department received an anonymous complaint with allegations the facility has had an increase in Covid-19 cases in the lockdown unit. Due to the anonymous complaint, I was unable to contact the complainant for additional information.

On 9/7/22, the allegations in this report were sent to centralized intake at Adult Protective Services (APS).

On 9/19/22, I interviewed resident service coordinator Candy Bitson at the facility. Ms. Bitson reported there was a Covid-19 outbreak in the secure memory care unit. Ms. Bitson reported residents and staff members tested positive for Covid-19. Ms. Bitson reported when the facility had the outbreak, they implemented infection control policies. Ms. Bitson reported staff members were to enter and exit from the unit and were not allowed to leave the unit until they completed their shift. Ms. Bitson reported the facility kept the same caregivers in the memory care unit to decrease the spread of Covid-19 to the assisted living unit. Ms. Bitson reported the facility did not have allow ancillary staff such as housekeeping in the unit and caregivers were responsible for completing these duties. Ms. Bitson reported residents were isolated to their room, as able. Ms. Bitson reported if a resident left their room, the caregivers encouraged them to wear a mask. Ms. Bitson reported the facility discouraged visitation. Ms. Bitson reported if there was a visitation, the visitor was screened for Covid-19 and was then escorted to the residents' room and was not allowed to walk throughout the facility. Ms. Bitson reported caregivers had access to personal protective equipment. Ms. Bitson reported when a resident tested positive for Covid-19, a cart was placed outside the resident's room with the necessary equipment. Ms. Bitson reported the facility managed the outbreak effectively.

On 9/19/22, I interviewed staff person 1 (SP1) at the facility. SP1 reported there was a Covid-19 outbreak in the memory care unit. SP1 reported during the outbreak, caregivers were not allowed to leave the unit. SP1 reported caregivers tried to isolate residents as much as possible. SP1 reported if residents left their room, they encouraged the resident to wear a mask. SP1 reported there was appropriate personal protective equipment within the unit and by each Covid-19 positive resident. SP1 reported the facility discouraged visitation but did allow visitors. SP1 reported the facility was effective in managing the outbreak.

On 9/19/22, I interviewed SP2 at the facility. SP2 statements were consistent with those made by SP1.

At the facility I observed the PPE storage containers used for Covid-19 positive residents. I observed the separate door that caregivers used during the outbreak.

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following: **(b) Assure that the home maintains an organized program to provide room and board, protection,**

	supervision, assistance, and supervised personal care for its residents.
For Reference: R 325.1901	**Definitions.**
	(16) "Protection" means the continual responsibility of the home to take reasonable action to ensure the health, safety, and well-being of a resident as indicated in the resident's service plan, including protection from physical harm, humiliation, intimidation, and social, moral, financial, and personal exploitation while on the premises, while under the supervision of the home or an agent or employee of the home, or when the resident's service plan states that the resident needs continuous supervision.
ANALYSIS:	Interviews conducted at the facility and observations made revealed the facility appropriately managed the Covid-19 outbreak.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Residents personal care needs are not met.

INVESTIGATION:

The complainant alleged residents appear unclean in the locked down unit.

Ms. Bitson reported residents are offered showers twice a week. Ms. Bitson reported residents can and sometimes will refuse a shower. Ms. Bitson reported the caregivers will work together to ensure the residents are clean. Ms. Bitson reported laundry is done weekly but if the resident is incontinent, it is done immediately. Ms. Bitson reported the residents are well taken care of in the unit.

SP1 reported residents will often refuse a shower but caregivers always offer a shower or a bed bath to the resident. SP1 reported with memory care residents, it can be difficult for the resident to agree to care. SP1 reported the caregivers know the residents' preferences with showers and can usually get the resident to agree. SP1 reported residents' laundry is done weekly. SP1 reported caregivers work together to ensure residents personal care needs are completed.

SP2 statements were consistent with those made by SP1.

I observed multiple residents at the facility. The residents did not appear to be disheveled as observed; the residents had clean clothes on, hair was brushed, and skin looked clean.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(1) Personal care and services that are provided to a resident by the home shall be designed to encourage residents to function physically and intellectually with independence at the highest practical level.
ANALYSIS:	Interviews conducted and observations made revealed lack of evidence that residents personal care needs are not met.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Employees speak rudely about residents.

INVESTIGATION:

The complainant alleged staff speak openly about some of the residents and refuse to assist with care due to race, illness, and all of the above.

Ms. Bitson reported employee's complete resident rights, resident abuse, and dementia training. Ms. Bitson reported recently she has not terminated an employee due to resident care issues. Ms. Bitson reported the caregivers work together and provide quality care to the residents.

SP1 reported caregivers provide care to all the residents. SP1 reported she never has heard of a caregiver refusing to provide care. SP1 reported at times the resident requires a change of caregiver due to preference. SP1 reported if there was a concern with a caregiver she would speak with a manager.

SP3 reported no concerns with staff and resident interactions. SP3 reported one resident has a cat and at times some caregivers do not like to provide care in the room, but they never refuse to provide care. SP3 reported residents receive good care at the facility.

I reviewed employee training for SP1, SP2, and SP3. The documents revealed the staff persons were trained on resident rights, resident abuse, and dementia.

At the facility I observed multiple interactions between residents and caregivers. The caregivers assisted residents to the dining room, assisted with re-direction, and had meaningful conversations with the residents.

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:	Interviews with caregivers and record revealed caregivers are trained in resident rights and caregivers treat residents with respect. Observations made at the facility revealed caregivers had meaningful and respectful conversations with each resident.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Facility has insufficient staff.

INVESTIGATION:

The complainant alleged there is lack of staff in the locked down unit.

Ms. Bitson reported there are 21 residents in the memory care unit. Ms. Bitson reported on first and second shift there is one medication technician and two resident service associates. Ms. Bitson reported on third shift there is one medication technician and one resident service associate. Ms. Bitson reported typically the caregivers do not leave the unit to provide care in the assisted living unit. Ms. Bitson reported there is also a “porter” employee that provides baths, activities, 1:1 care, and other required tasks. Ms. Bitson reported the facility also has an 7:00-12:00pm shift and a 4:00-8:00pm shift to assist the staff during the busy times. Ms. Bitson reported the facility does not have a mandation policy and management will work the floor, if needed. Ms. Bitson reported when the schedule is developed the open shifts are offered to employees for overtime. Ms. Bitson reported employees work together to ensure the open shifts are covered. Ms. Bitson reported the facility is currently hiring for first and second shifts. Ms. Bitson reported there is sufficient staff to meet the needs of the residents.

SP1 reported the memory care unit typically has at least two resident service associates and a medication technician. SP1 reported usually there is another caregiver until 12:00pm to assist with the busy times of the day. SP1 reported the acuity is low in the unit and the needs of the residents are met.

SP2 reported typically there is at least two resident care associates and one medication technician. SP2 reported at times, employees will not show up for their shift and management will assist, if needed. SP2 reported resident needs are met.

SP3 reported employees work together to ensure the needs of the residents are met and tasks are accomplished. SP3 reported no concerns with staffing levels.

At the facility, I observed five staff members in the unit. The staff members were visible and were providing care to the residents.

I reviewed the staff schedule for 8/28-9/10. The schedule revealed the staffing ratios were consistent with those described by Ms. Bitson.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(5) The home shall have adequate and sufficient staff on duty at all times who are awake, fully dressed, and capable of providing for resident needs consistent with the resident service plans.
ANALYSIS:	Interviews with management and staff persons revealed there are no concerns with staffing levels at the facility. In addition, review of staff schedules revealed the facility is operating at their desired staffing levels. There is lack of evidence to support the allegation and therefore the violation is not established.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Facility has an odor.

INVESTIGATION:

The complainant alleged there is an odor at the facility.

Ms. Bitson reported the facility has a full-time housekeeper. Ms. Bitson reported during the Covid-19 outbreak, caregivers were to complete housekeeping tasks as the housekeeper was not allowed in the unit. Ms. Bitson reported residents' rooms are cleaned once weekly and more if needed. Ms. Bitson reported the common areas are cleaned daily.

SP1 reported the facility is kept clean. SP1 reported the housekeepers are responsible for cleaning residents' rooms and the common area. SP1 reported the employees will also clean, if needed.

I observed the common areas of the facility including the living area, dining area, hallways, and bathrooms. The common areas of the facility were clean as observed by the floors were vacuumed, there was no litter on the floor, and the facility smelt clean.

I observed multiple resident rooms and bathrooms. The rooms were tidy and clean. The bathrooms were also clean. I did not smell any odors.

APPLICABLE RULE	
R 325.1979	**General maintenance and storage.**
	(1) The building, equipment, and furniture shall be kept clean and in good repair.
ANALYSIS:	Interviews with employees and observations made at the facility revealed the facility is kept clean. There is lack of evidence to support the allegation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

I recommend no change in the status of the license.

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Kimberly Horst Date
Licensing Staff

Approved By:

09/26/2022

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