GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 19, 2022

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

RE: License #: AH410236873
Investigation #: 2023A1021013
Railside Assisted Living Center

Dear Mrs. Gowman:

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 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 (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 #:	AH410236873
Investigation #:	2023A1021013
Complaint Receipt Date:	11/09/2022
Investigation Initiation Date:	11/14/2022
Report Due Date:	1/09/2022
Licensee Name:	Railside Living Center LLC
Licensee Address:	950 Taylor Street Grand Haven, MI 49417
Licensee Telephone #:	(616) 842-2425
Administrator:	Tracy Wood
Authorized Representative:	Lauren Gowman
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
License Status:	REGULAR
Effective Date:	02/07/2022
Expiration Date:	02/06/2023
Capacity:	121
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A unsupervised at the facility.	Yes
Additional Findings	No

III. METHODOLOGY

11/09/2022	Special Investigation Intake 2023A1021013
11/14/2022	Special Investigation Initiated - Telephone Interviewed resident service coordinator
11/14/2022	Contact - Document Received received Resident A's documents
11/22/2022	Contact-telephone call made Interviewed SP1
11/22/2022	Contact-telephone call made Interviewed SP2
12/19/2022	Exit Conference Exit Conference with authorized representative Lauren Gowman

ALLEGATION:

Resident A unsupervised at the facility.

INVESTIGATION:

On 11/09/22, the licensing department received a complaint with allegations Resident A fell at the facility due to lack of supervision. The complainant alleged Resident A was placed in assisted living on 10/24/22. The complainant alleged on 10/24/22, around 10:00pm, Resident A rang for assistance and no caregivers responded until 10:45pm. The complainant alleged Resident A fell at the facility sometime between 11:30pm and 1:00am. The complainant alleged the facility reported Resident A was fine but a few hours later Resident A was transferred to the hospital with diagnosis of a broken hip.

On 11/14/22, I interviewed resident service coordinator Lori Krause by telephone. Ms. Krause reported Resident A admitted to the facility from home on 10/24/22. Ms. Krause reported Resident A had a diagnosis of Lewy Body Dementia but was alert and orientated. Ms. Krause reported Resident A did not exhibit behaviors consistent with memory loss or elopement so it was determined that Resident A could reside in the assisted living center. Ms. Krause reported Resident A was found on the floor by the caregivers in the night on 10/24/22 or 10/25/22. Ms. Krause reported Resident A reported Resident A reported different reports as to how she fell. Ms. Krause reported Resident A reported she was getting up to go to the bathroom and that she was trying to get a book from her bedside table. Ms. Krause reported at the time of the fall Resident A reported some discomfort in her ribs but no pain. Ms. Krause reported Resident A had no injuries and vitals were within normal range. Ms. Krause reported at the time of the fall it took three people to get her off the floor and back into bed. Ms. Krause reported Relative A1 was called and a message was left. Ms. Krause reported for the remainder of the night, Resident A was checked on every 20-25 minutes. Ms. Krause reported around 5:10am the medication technician heard yelling from Resident A's room and Resident A reported her leg hurt. Ms. Krause reported the facility sent Resident A to the hospital to be evaluated. Ms. Krause reported Resident A did break her hip. Ms. Krause reported Resident A re-admitted to the facility and passed away on 11/6/22.

On 11/22/22, I interviewed staff person 1 (SP1) by telephone. SP1 reported she worked the night Resident A fell at the facility. SP1 reported she was walking by Resident A's room and heard Resident A yelling for help. SP1 reported she walked into Resident A's room and observed Resident A on the floor. SP1 reported when asked about the fall, Resident A had different stories including reaching for a book on her nightstand or trying to go to the bathroom. SP1 reported Resident A was impulsive and never pressed her call light for assistance. SP1 reported Resident A complained of some pain but range of motion was appropriate. SP1 reported at time of fall, there was no signs of injury.

On 11/22/22, I interviewed SP2 by telephone. SP2 reported she observed Resident A on the floor in her room. SP2 reported Resident A was naked from the waist down. SP2 reported Resident A reported she slipped out of bed. SP2 reported Resident A reported of pain. SP2 reported Resident A winced in pain when range of motion was completed. SP2 reported the medication technician, supervisor, and aid were present in the room. SP2 reported the administrator was called to confirm course of action. SP2 reported the administrator advised the staff persons to keep an eye on Resident A throughout the night. SP2 reported frequent checks were completed on Resident A throughout the night. SP2 reported around 4:00am Resident A was moaning in pain and Resident A was then transferred to the hospital.

I reviewed call light response time for Resident A. The document revealed on Resident A's call light was activated on 10/24 at 8:36pm and was responded to at 9:18pm which was a 42 minute response time.

I reviewed the service plan for Resident A. The service plan read,

> *"I need the assistance of 1 person to help me my daily toileting needs. Daily @ 8:00am, 11:00am, 2:30pm, 5:00pm, 8:00pm, 11:00pm, 2:00am, 5:00am, as needed. I require or request to have visual checks 3 times during the night. Daily @ 12:00am, 3:00am, 6:00am."*

I reviewed observation notes for Resident A. The notes read,

> *"10/24/22: this resident is a new admit. Resident is A&O x3, pleasant and cooperative and able to make needs known. Resident is a one assist with four wheeled walker and would probably benefit from a gait belt. Will have resident staff place one in resident's room. VSS and PERRLA are WNL, B/P 102/62, pulse 70, resp 18, temp 96.8, SP02 at 95% RA. Resident WT is 164.2 lbs. No c/o pain voiced at this time. No concerns voiced. Resident was resting in recliner at this time, with call light in reach. Family and friends in room visiting with resident. Will continue to monitor.*
> *10/24: move in charting—resident was visiting with family at the time of this charting. Family requested extra checks tonight as this is her first night here. She is alert and aware of her surroundings. She is pleasant to speak with. She takes her medications whole with water. She needs toileting at night from what I understand from the family. Her blood pressure was high 155/102 on the first try, the 2nd try was lower but not low enough on the 3rd try MT placed residents arm across her chest and got a better read for the blood pressure. Overall good spirits.*
> *10/25: SP2 was doing visuals and heard (Resident A) yelling from her room. She went in and observed her sitting on her bottom in the middle of her floor by the wall of her bathroom. (SP2) called "code white" over the walkie. (SP1) went to (Resident A) and observed her on the floor sitting on her bottom. (SP3) then called (SP1) to come to the resident's room. ROM was done and vitals were obtained. This resident was c/o left thigh pain but ROM was done without assistance. This resident's BP was elevated the first time of the fall. She was a three assist to get off the floor and back into bed. (SP3) rechecked her vitals and they were as follows: bp-175/71 p-96. (SP1) called administrator at 12:58am and spoke with her about the incident. (SP1) also called (Relative A1) at 1:06am but no answer so a voicemail was left. The resident was observed to be very confused about the incident and unsure of what happened. She denied any new or worsening pain once in bed. This (SP3) rechecked her BP once settled in bed and it was 141-71.*
> *10/25: add on to previous observations about the fall on 10/25/22 at 12:40am, She was checked on about every 20-25 mins post fall, she had no c/o new pain and was toileting and walked to the bathroom with staff without complaints. Around 5:15am, (SP1) heard yelling from this resident's room and went in there asking what was wrong. The resident stated that her left leg hurts when she moves it. (SP1) called (SP2) over the walkie to assist in the resident's room. At 5:19am, (SP3) and Life EMS were called and (Relative A1) was called to let him*

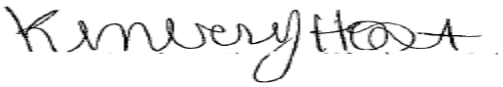
know she is being sent out to the ED for evaluation. She was picked up by EMS at 5:32am."

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:	Resident A was to be toileted at 8:00pm yet her call light was activated for toilet assistance at 8:36pm and the call light was not responded to until 9:18pm. The facility lacked appropriate supervision and protection for Resident A as demonstrated by not providing care in accordance with her service plan and the extended call light respond time.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 12/19/22, I conducted an exit conference with authorized representative Lauren Gowman by telephone.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend no change in the status of the license.



12/12/2022

Kimberly Horst Date
Licensing Staff

Approved By:

12/16/2022

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