GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 21, 2023

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

RE: License #: AH410236873
Investigation #: 2023A1028056
Railside Assisted Living Center

Dear Mrs. Gowman:

Attached is the Special Investigation Report for the above referenced facility. 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 party 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 I am not available, and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

Julie Viviano

Julie Viviano, Licensing Staff
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

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

I. IDENTIFYING INFORMATION

License #:	AH410236873
Investigation #:	2023A1028056
Complaint Receipt Date:	06/05/2023
Investigation Initiation Date:	06/05/2023
Report Due Date:	08/05/2023
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:	02/07/2023
Expiration Date:	02/06/2024
Capacity:	121
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A was not provided required supervision or assistance resulting in multiple falls with injury.	Yes
Additional Findings	No

III. METHODOLOGY

06/05/2023	Special Investigation Intake 2023A1028056
06/05/2023	Special Investigation Initiated - Letter 2023A1028056
06/05/2023	APS Referral APS made referral to HFA.
06/06/2023	Contact - Face to Face Interviewed Admin/Tracy Wood at the facility.
06/06/2023	Contact - Face to Face Interviewed Employee A at the facility.
06/06/2023	Contact - Face to Face Interviewed Employee B at the facility.
06/06/2023	Contact - Face to Face Interviewed Employee C at the facility.
06/06/2023	Contact - Document Received Received Resident A's record from Admin/Tracy Wood.

ALLEGATION:

Resident A was not provided required supervision or assistance resulting in multiple falls with injury.

INVESTIGATION:

On 6/5/2023, the Bureau received the allegations through Centralized Intake.

On 6/5/2023, Adult Protective Services (APS) made the referral to Homes for the Aged (HFA) through Centralized Intake.

On 6/6/2023, I interviewed facility administrator, Tracy Wood, at the facility who reported Resident A began to decline in 2021, requiring use of Hoyer lift for safety. Ms. Wood reported Resident A was very resistant when using the Hoyer lift despite decline in function from previous stroke and was often very aggressive and/or hostile with staff. Resident A had some residual cognitive issues due to the previous stroke but was allowed to make own decisions because Resident A's spouse was the authorized representative and resided at the facility with Resident A as well. However, Resident A was often non-compliant with staff instructions jeopardizing [their] own safety and staff safety. Resident A often had outbursts, would refuse to use the call pendant, or not wait for staff assistance when the call pendant was utilized. Due to continued non-compliance and behaviors, a 30-day discharge was recently issued to Resident A. Ms. Wood reported on 4/23/2023, Resident A incurred a fall because Resident A got up on [their] own to attend Bingo. Emergency services were called with Resident A being transported to the hospital for further evaluation due to reports of pain in left shoulder, hip, and leg. Resident A did not return to the facility. Ms. Woods provided me Resident A's record for my review.

On 6/6/2023, I interviewed Employee A at the facility who reported Resident A incurred a prior stroke leading to a decline in function resulting in the required use of a Hoyer lift for safety. Employee A reported Resident A often refused to use the Hoyer lift and was difficult with staff concerning its use. Resident A could also be difficult during care routines due to refusing to use a bedpan or bedside commode. Facility staff followed physical therapy orders due to Resident A's decline in function with Resident A demonstrating growing anger and frustration with staff. Employee A reported Resident A would become very angry and yell and curse at staff. Resident A also would make threats of physical harm towards staff and had hit and kicked staff in the past. Employee A reported Resident A was non-compliant with staff instructions which compromised [their] own safety and staff's safety as well. Employee A reported Resident A was also not compliant with use of the call pendant and would get up on [their] own despite staff instruction to wait for staff assistance. Employee A reported Resident A "did not like using the Hoyer lift. [They] wanted to be able to get up on [their] own and go to the bathroom by [themselves]. [Resident A] had a hard time accepting [they] were declining and required assistance with everything". Employee A confirmed Resident A fell on 4/23/2023 due to not waiting for staff assistance. Resident A was sent to the hospital for further evaluation and did not return to the facility.

On 6/6/2023, I interviewed Employee B and Employee C at the facility whose statements are consistent with Ms. Wood's statements and Employee A's statements.

On 6/6/2023, I completed an on-site inspection due to this investigation. Residents observed were clean and well-groomed and being assisted by staff appropriately.

On 6/12/2023, I reviewed Resident A's service plan which revealed the following:

- Resident A required one-person assist with bed bath, grooming, peri-care, wheelchair mobility, and C-PAP machine set-up. Spouse could assist with wheelchair mobility as well.
- Resident A required two-person assist with upper and lower body dressing, toileting, transferring (using Hoyer lift), and management of bedpan and/or bedside commode.
- Resident A was independent with eating and did not have a special diet.
- The facility managed all medications and housekeeping.
- Resident A demonstrated behaviors to include yelling, cursing, anger, physical aggression (to include hitting and kicking) due to physical limitations. Staff were instructed to address and validate Resident A's concerns, ensure Resident A's safety, use strategies to avoid inciting behaviors, and report behaviors to supervisor if they occur.
- Resident A is an increased fall risk due to cognition, left side hemiplegia, and body size.
- Resident A's call pendant is to be placed around Resident A's neck after care is completed.

I reviewed Resident A's record notes which revealed the following:

- Resident A had a history of behaviors towards staff to include yelling, cursing, threatening to "break staff's necks", kicking, throwing items, and outbursts in common areas in front of other residents.
- Facility staff addressed Resident A's concerns, increased pain levels, and desire to transfer to the toilet instead of using bedpan, bedside commode, or Hoyer lift.
- Evidence of communication with Resident A's family.
- Resident A demonstrating inconsistent ability to transfer to bathroom toilet compromising own safety with discharge from physical therapy due to plateauing with transfers and functional mobility.
- Resident A's continued frustration and growing anger with staff not allowing use of the bathroom toilet, despite physical therapy orders in place.
- Staff following physical therapy orders for Resident A to not use the bathroom toilet due to weakness and inability to stand safely.
- Refusals of care with family called to facility to assist.
- Non-compliance with use of the call pendant.

I reviewed the incident report pertaining to the fall on 4/23/2023 which revealed the following:

- At 1:45 pm, Resident A was assisted by staff with use of the bedpan. Staff last observed Resident A in the wheelchair in [their] room between 2:15 pm to 2:30pm.

- Resident A was discovered in [their] room on the floor by a family member at 3:00 pm. Resident A had shoes on and was lying near the wheelchair.
- Resident A stated [they] were attempting to get up from the wheelchair to go to Bingo.
- Resident A did not have [their] call pendant at the time of the fall because staff had taken it to fix it because there was difficulty resetting it. A replacement call pendant or alternative method to alert staff for assistance was not provided at that time.
- Resident A complained of pain in left shoulder, hip, and leg and was sent to the hospital for further evaluation.

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.**

ANALYSIS:	It was alleged Resident A was not provided the required supervision or assistance resulting in multiple falls with injury. Interviews, on-site investigation, and review of documentation reveal Resident A had a demonstrated history of non-compliance and behaviors during transfers, functional mobility, and with care routines. On 4/23/2023, Resident A incurred a fall resulting in injury and subsequent transport to the hospital. Staff had previously assisted Resident A with care in [their] room at 1:45 pm. Staff were unable to reset the call pendant appropriately at this time and took the call pendant to try and fix it. Resident A was last observed by staff sitting in the wheelchair between 2:15 pm to 2:30 pm in [their] room. At 3:00 pm, Resident A was found on the floor by a family member with complaints of pain to left side of the body. At that time, Resident A's call pendant still had not been returned, leaving Resident A unable to call for staff assistance to potentially prevent the fall. There is no evidence a replacement call pendant or alternative method was provided to Resident A to alert staff for assistance while the initial call pendant was being fixed and/or reset. The facility did not provide Resident A appropriate supervision, a replacement call pendant, or an alternative method to alert staff for assistance which jeopardized Resident A's overall safety and wellbeing; and contributed to Resident A's fall with injury. Therefore, the facility is in violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an approved corrective action plan, I recommend the status of the license remain the same.

Julie Viviano

6/22/2023

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Julie Viviano Date
Licensing Staff

Approved By:

08/17/2023

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