GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

November 27, 2024

Santanu Ray
Harborside Senior Living
10701 Valleywood Ave
Luna Pier, MI 48157

RE: License #: AH580403754
Investigation #: 2025A1027010
Harborside Senior Living

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 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,

Jessica Rogers

Jessica Rogers, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 285-7433
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH580403754
Investigation #:	2025A1027010
Complaint Receipt Date:	11/15/2024
Investigation Initiation Date:	11/18/2024
Report Due Date:	01/15/2025
Licensee Name:	Harborside Senior Living LLC
Licensee Address:	10701 Valleywood Ave Luna Pier, MI 48157
Licensee Telephone #:	(734) 636-4000
Administrator:	Kaushikkuma Patel
Authorized Representative:	Santanu Ray
Name of Facility:	Harborside Senior Living
Facility Address:	10701 Valleywood Ave Luna Pier, MI 48157
Facility Telephone #:	(734) 636-4000
Original Issuance Date:	01/25/2023
License Status:	REGULAR
Effective Date:	08/01/2024
Expiration Date:	07/31/2025
Capacity:	30
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident A eloped.	Yes
Additional Findings	No

III. METHODOLOGY

11/15/2024	Special Investigation Intake 2025A1027010
11/18/2024	Special Investigation Initiated - Letter Email sent to administrator to request documentation for allegations pertaining to Resident A
11/20/2024	Inspection Completed On-site
11/25/2024	Contact - Document Received Email received from Employee #1 with requested documentation
11/26/2024	Inspection Completed-BCAL Sub. Compliance
11/27/2024	Exit Conference Conducted by email with Kaushikkuma Patel and Santanu Ray

ALLEGATION:

Resident A eloped.

INVESTIGATION:

On 11/15/2024, the Department received allegations from Adult Protective Services (APS) regarding an incident on 11/8/2024, between 4:30 AM and 5:15 AM, in which Resident A walked out of the facility. Employee #1, who was working at the time, did not observe Resident A leaving the facility. It was reported that Resident A exited through the front entrance and fell outside. Both Resident A's family and Careline Hospice Agency were notified of the incident.

On 11/20/2024, I conducted an on-site inspection at the facility and interviewed Employee #1.

Employee #1 confirmed the allegations were accurate. She stated that the facility had seven residents that night and she was working alone. Employee #1 explained that she was attending to another resident when Resident A eloped and she saw him outside the facility. Employee #1 further noted that Resident A

had not attempted to elope before, and that no other residents had done so either. She also stated that all residents required one person or stand-by assistance for care.

A review of Resident A's face sheet indicated that he moved into the facility on 12/29/2023. His service plan noted that he required assistance from one or two staff members for locomotion, either using a walker or a wheelchair, and identified him as a fall risk.

The Pre-Admission Assessment for Resident A, dated 12/26/2023, stated that he had minimal to substantial dependence regarding his propensity to wander and experienced some memory lapses. It was noted that cues were necessary to redirect him from wandering.

The incident report for Resident A, dated 11/9/2024, described an event around 4:30 AM. Employee #1 observed Resident A in the dining area while she was retrieving a spoon for another resident. Upon returning to the dining area, Resident A was no longer there. Employee #1 conducted a search of all resident rooms, then went outside where she found him on the ground. The report indicated that Resident A had scrapes and bleeding on his forehead and knee. Careline Hospice and his family were contacted following the incident.

On 11/26/2024, a telephone interview with Employee #1 revealed that Resident A was located before 5:00 AM that morning.

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.**
	(t) "Service plan" means a written statement prepared by the home in cooperation with a resident, the resident's authorized representative, or the agency responsible for a resident's placement, if any, that identifies the specific care and maintenance, services, and resident activities appropriate for the individual resident's physical, social, and behavioral needs and well-being, and the methods of providing the care and services while taking into account the preferences and competency of the resident.

R 325.1924	**Reporting of incidents, quality review program.**
	(7) The facility must have a policy and procedure to ensure that an incident, once known by facility staff, is reported as soon as possible, but not later than 48 hours after the incident, to a resident's authorized representative or designated health care professional, as appropriate. Verbal or written notification must be documented in the resident's record to reflect the date, time, name of staff who made the notification, and name of the representative or professional who was notified.
ANALYSIS:	Although an interview with Employee #1 indicated that Resident A had not previously eloped, a review of his pre-admission assessment revealed that he had a propensity to wander, which was not reflected in his service plan for staff. Furthermore, the incident report lacked key details, including the time Resident A was located, the corrective measures taken to ensure his safety, and the date and time his authorized representative and hospice agency were notified.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of this license remain unchanged.

11/26/2024

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Jessica Rogers Date
Licensing Staff

Approved By:

11/27/2024

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