GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 2, 2024

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

RE: License #: AH610255010
Investigation #: 2025A1021010
Seminole Shores Assisted Living Center

Dear Lauren 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 #:	AH610255010
Investigation #:	2025A1021010
Complaint Receipt Date:	10/24/2024
Investigation Initiation Date:	10/24/2024
Report Due Date:	12/23/2024
Licensee Name:	Seminole Shores Operating Company
Licensee Address:	950 Taylor Avenue Grand Haven, MI 49417
Licensee Telephone #:	(616) 842-2425
Administrator:	Mallory Hollomon
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:	06/17/2024
Expiration Date:	07/31/2024
Capacity:	129
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A had multiple falls.	Yes
Resident A's care was inconsistent.	Yes
Resident A dietary needs are not met.	Yes
Additional Findings	No

III. METHODOLOGY

10/24/2024	Special Investigation Intake 2025A1021010
10/24/2024	Special Investigation Initiated - Telephone interviewed complainant
10/25/2024	Inspection Completed On-site
11/06/2024	Contact-Telephone call made Interviewed Life Circles
12/02/2024	Exit Conference

ALLEGATION:

Resident A had multiple falls.

INVESTIGATION:

On 10/24/2024, the licensing department received a complaint with allegations Resident A had multiple falls at the facility.

On 10/24/2024, I interviewed the complainant by telephone. The complainant alleged the family was aware Resident A had a few falls, but it was later found out Resident A had at least five falls while at the facility.

On 10/25/2024, I interviewed administrator Mallory Hollomon at the facility. Administrator reported Resident A had a court appointed legal guardian that was not family and after each fall the guardian would be notified. Administrator reported there

was not a secondary contact listed to notify for Resident A. Administrator reported Resident A did have a few falls at the facility due to impulsivity. Administrator reported Resident A was very unsteady and would not remember to call for help. Administrator reported Resident A would often try to get up on her own and then fall. Administrator reported Resident A would not use her pendent to call for help. Administrator reported when a fall occurred, the physician and the legal guardian was notified as that was the only people that were to be contacted.

On 10/25/2024, I interviewed staff person 3 (SP3) at the facility. SP3 reported Resident A did have falls at the facility. SP3 reported Resident A would sit on the edge of her wheelchair and then slide out of the wheelchair. SP3 reported Resident A had motion alarms to alert staff when Resident A was moving. SP3 reported Resident A did not use her call pendent for assistance.

I reviewed facility incident reports for Resident A falls. The reports read,

"07/30: RSA was doing rounds and called Code White. RSA and Shift Supervisor responded. Resident was observed sitting up on the floor in front of her wheelchair facing window. Resident denied hitting head and denied pain. Assessed for injuries with none to note. Prior to fall, resident was observed sitting in her wheelchair at her table. Resident was wearing pendent necklace but had removed it herself. Motion alarms were in place. Resident was barefoot at time of fall. Resident assisted back into wheelchair using camel device and gait belt. Intervention: Keep dycem between chair pad and motion alarm. Physician and guardian notified.
08/11: Med tech entered the resident's apartment to respond to her chair alarm and observed the resident at the edge of her wheelchair about to fall out. Shift supervisor was called to assist; by that time when the shift supervisor entered the apartment, the resident slid her feet forward and slid herself out of the chair onto her bottom. The resident was observed sitting on her bottom on the floor in front of her wheelchair. The resident has been barefooted at the time of the incident. When asked what happened? The resident stated, "I was just trying to put my socks on." The resident uses a wheelchair to ambulate. The resident utilizes bed and chair alarms, both functional at the time of the fall. The resident had a pendent necklace at the time of the fall, but she did not activate it for assistance. Vitals were obtained. The resident denied hitting her head and did not have any visible injuries. Range of motion was performed and was within the resident's limits. The CAMEL device assisted the resident off the floor because she could not reposition herself to her knees. The resident's doctor, POA/sister, RSC, and the administrator were notified. Intervention to encourage the resident to use a pendent for assist.
09/18: RSA was responding to the motion alarm and called Code White. Med Tech and Shift Supervisor responded. The resident was observed sitting up in front of her wheelchair facing her craft table with her back against her wheelchair and legs outstretched in front of her. The resident denied hitting the head and had no complaints of new pain. The resident was unwilling to inform staff how the

fall occurred. No signs of injury. Before the fall, the resident was observed sitting in a wheelchair watching television. Resident wearing socks at the time of fall. The resident does not wear a pendant and the call light was not within reach. A resident has a motion alarm in wheelchair that was sounding at the time of the fall. The resident assisted up using a camel device. Intervention: Added visual checks throughout the day. POA, PCP, RSC, and Admin were all notified.
09/26: RSA was responding to the residents motion alarm when she entered the apartment the resident was observed on the floor, she called a code white. Shift supervisor and med tech responded. The resident was observed on her hands and knees with her head stuck in between her bed and night stand, her halo bar was snapped on her bed. The night stand was moved so the resident could be assisted and assessed. The resident was crying in pain, stated that her head and neck really hurt. The resident has a scrape on her right shoulder, a red area on her forehead, and another red mark on her neck near her collar bone. Range of motion was performed, and was within normal limits. Vitals were obtained and relayed to EMS and residents physician. Her head and neck were not moved due to the possibility of a neck injury, and because she hit her head. EMS was called at 4:29am and left with the resident at 4:56am. When asked what happened the resident only stated "I was getting out bed." When asked for further details she did not respond to the questions being asked. She uses a wheelchair with the assistance of staff to ambulate, which was not in use at the time of the incident. She does have both bed and chair alarms, which were working properly at the time of the fall. The resident also has a pendent which was around her neck at the time, she did not activate the alarm for assistance before or after the fall. She was barefoot at the time of the incident. The CAMEL was not utilized because EMS moved the resident onto a stretcher. RSC, administrator, POA, EMS, and the resident's physician were notified. Reasonable intervention: Reminded resident to push her pendent and wait for assistance with all transfers."
10/03: RSA was responding to a motion alarm and called Code White. Shift supervisor and Med Tech responded. Resident was observed on her knees, holding on to halo bar with right hand and facing the bed. Shortly before the fall, resident was adjusted in repositioning in bed after attempting to get up and walk without assistance. Resident had no visible injuries and denied any new pain. Resident has wheelchair that was across the room and bed alarm was in place and sounding. Resident denied hitting her head and there were no redness, swelling or marks to indicate that she did. Call light was not within reach and resident does have a pendent but did not utilize it. Resident assisted off the floor and back into bed using Hoyer lift. Intervention: Increase in visual checks. Notification: Physician and guardian.

I reviewed Resident A's Personal Needs Assessment. The assessment read,

"Higher risk of falls. Intervention: 7/30/24-Keep dycem between chair pad and motion alarm. 08/11/24: Intervention: Request med review for evening medications.

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.**
	(p) "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:	Review of documentation revealed Resident A did not use pendent for assistance and would often fall due to not requesting assistance. After each fall, interventions would be put in place to ensure the protection and safety of Resident A. However, these interventions, to encourage use of pendent, were not appropriate as Resident A was documented as not using the pendent. In addition, the intervention of increase visual checks was detailed in Resident A's service plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A's care was inconsistent.

INVESTIGATION:

The complainant alleged Resident A had a wound on her coccyx that required wound care. The complainant alleged there were times Resident A was found without the appropriate wound care bandage. The complainant alleged there were times Resident A's bed and body was covered in feces.

Administrator reported Resident A had a significant wound on her coccyx that was managed by Life Circles. Administrator reported the care staff do not provide wound

care as they are not trained. Administrator reported Life Circles would provide wound care every 1-2 days. Administrator reported there were times Resident A's family would take the bandage off as the bandage looked soiled. Administrator reported the type of bandage that was used by Life Circles ensured no fecal matter would get into the wound, even if the bandage appeared soiled. Administrator reported Resident A was incontinent and did wear briefs. Administrator reported Resident A was on a two-hour toileting schedule. Administrator reported Resident A's room was located near the care station and Resident A would often receive checks and change more often than every two hours.

On 10/25/2024, I interviewed SP1 at the facility. SP1 reported Resident A was incontinent and had loose stools. SP1 reported Life Circles was in to provide wound care almost every day. SP1 reported if Resident A had no bandage on, Life Circles would come and change the bandage.

On 10/25/2024, I interviewed SP2 at the facility. SP2 reported Resident A admitted to the facility with the wound and the wound progressed quickly. SP2 reported the bandage would come off and Life Circles would have to come and change it. SP2 reported care staff were responsible for putting cream on the wound. SP2 reported Resident A had so many loose and watery stools, that at times her Depend and herself may have been covered in feces. SP2 reported Resident A was never left for an extended time with a soiled Depend.

SP3 reported Resident A was to be checked and changed every two hours. SP3 reported Resident A's room was close to the care station and she would often be changed sooner than two hours. SP3 reported at times it would appear there was fecal matter under the bandage and care staff would remove the bandage. SP3 reported Life Circles would have to come and change the bandage.

On 10/25/2024, I interviewed SP4 at the facility. SP4 reported Resident A was active with Life Circles for wound care. SP4 reported it was hard to determine if the bandage had fecal matter or pus in it. SP4 reported there were times care staff would take the bandage off and Life Circles would have to come change it.

On 11/06/2024, I interviewed Life Circles registered nurse Emma Meyers by telephone. Ms. Myers reported after extensive research it was found that Resident A's wound started internally not externally. Ms. Meyers reported Life Circles has a great working relationship with the facility. Ms. Meyers reported Life Circles was responsible for wound care and provided wound care multiple times a week. Ms. Meyers reported while she did observe Resident A with a soiled Depend, it was not on Resident A for long and care staff were always attentive to Resident A's needs.

I reviewed Resident A's *Personal Needs Assessment*. The assessment read, "*Toileting: Assistance of 2 people. Daily at 8:00am, 10:00am, 12:00pm, 2:00pm, 4:00pm, 6:00pm, 8:00pm, 10:00pm."*

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 conducted revealed Life Circles was to change the bandage and provide wound care. However, additional interviews conducted revealed at times, care staff would apply barrier cream and change the bandage. In addition, review of Resident A's service plan revealed lack of information on the wound care, Life Circles involvement, and the incontinence of Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Resident A dietary needs are not met.

INVESTIGATION:

The complainant alleged Resident A ate majority of her food in her room and required assistance with eating. The complainant alleged there were multiple times un-touched meals were found not near Resident A in Resident A's room. The complainant alleged staff did not assist with feeding Resident A.

Administrator reported prior to Resident A's health decline, Resident A did eat meals in the dining room. Administrator reported when Resident A's health started to decline, Resident A preferred to eat meals in her room. Administrator reported Resident A had a tray in her room for the meals to be placed on. Administrator reported Resident A did not require any promoting or assistance with eating. Administrator reported culinary staff deliver the food trays and care staff pick up the food trays. Administrator reported if the staff observe the food was not eaten, they will encourage the resident to eat. Administrator reported Resident A's appetite had decreased and Resident A was not eating much.

SP1 reported near the end of Resident A's admission, Resident A was bed bound and was eating all meals in her room. SP1 reported Resident A had a hospital table for the food to be placed on. SP1 reported a few times she did observe the food container was placed across the room from Resident A.

SP2 reported Resident A did eat most meals in her room. SP2 reported Resident A was not a big eater but did drink Ensure drinks. SP2 reported Resident A was on finger food diet.

I reviewed Resident A's *Personal Needs Assessment*. The assessment read,
"meal time assistance: independent. I am on a regular diet with no restrictions."

I reviewed Resident A's observation notes. The notes read,
"09/26: Received an order for special instructions for diet. Feeding assistance with set up at meals, NO pork or fish and finger foods at meals."

APPLICABLE RULE	
R 325.1953	**Menus.**
	(4) Medical nutrition therapy, as prescribed by a licensed health care professional and which may include therapeutic diets or special diets, supplemental nourishments or fluids to meet the resident's nutritional and hydration needs, shall be provided in accordance with the resident's service plan unless waived in writing by a resident or a resident's authorized representative.
ANALYSIS:	Review of documentation revealed Resident A required feeding assistance with a diet of finger foods. However, this information was not reflected in Resident A's personal assessment.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

11/12/2024

Kimberly Horst Date
Licensing Staff

Approved By:

11/27/2024

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