GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 4th, 2025

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

RE: License #: AH410236873
Investigation #: 2025A1021068
Railside 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) 335-5985.

Sincerely,
Kimberly Horst

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 #:	2025A1021068
Complaint Receipt Date:	07/22/2025
Investigation Initiation Date:	07/23/2025
Report Due Date:	09/21/2025
Licensee Name:	Railside Living Center LLC
Licensee Address:	950 Taylor Street Grand Haven, MI 49417
Licensee Telephone #:	(616) 842-2425
Administrator:	Shannon Del Raso
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:	08/01/2025
Expiration Date:	07/31/2026
Capacity:	121
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A's family is not allowed to visit.	No
Resident A is not cared for.	No
Resident A's medications were not updated timely.	Yes
Additional Findings	No

III. METHODOLOGY

07/22/2025	Special Investigation Intake 2025A1021068
07/23/2025	Special Investigation Initiated - Telephone interviewed the complainant
07/28/2025	Inspection Completed On-site
	Exit Conference

ALLEGATION:

Resident A's family is not allowed to visit.

INVESTIGATION:

On 07/22/2025, the licensing department received a complaint with allegations that Resident A's family is not allowed to visit.

On 07/23/2025, I interviewed the complainant by telephone. The complainant alleged Resident A's family has been harassed by facility workers and workers have videotaped the family at the facility. The complainant alleged Resident A's family is unable to bring a telephone into the facility and allow for Resident A to use the telephone. The complainant alleged some members of Resident A's family are unable to visit.

On 07/28/2025, I interviewed facility administrator Shannon Del Raso at the facility. The administrator reported there have been many family dynamics with Resident A. The administrator reported Resident A now has a court appointed guardian. The administrator reported Resident A's family came to the facility and began to video tape caregivers and other residents were in the video. The administrator reported this is not allowed due to the potential of a HIPPA violation. The administrator

reported Relative A1 has also screamed in the hallways and the police department was contacted due to the disturbance. The administrator reported that she contacted Relative A1 for Relative A1 to acknowledge and sign a visitor agreement. The administrator reported it was requested for Relative A1 to leave her telephone out of the facility due to the history of Relative A1 videotaping staff. The administrator reported Resident A has access to the facility telephone if she wishes to contact someone. The administrator reported that no family members have been banned from the facility, there are only parameters put in place to ensure the safety and protection of staff and residents.

On 07/28/2025, I interviewed Resident A at the facility. Resident A reported her family visits as they are available. Resident A reported if she wished to call someone staff would help her contact her family.

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

06/20/2025: D5 brought concerns to me about (Resident A)'s family member that visited the other day. D5 was concerned about the safety of (Resident A) when (Resident A's) family member was yelling in the halls. D5 stated the family member was frightening her and not kind to (Resident A).
"06/20/2025: I let (Relative A1) know that staff person 1 (SP1) was done with the conversation about court things. I let (Relative A1) know that (SP1) was done with the conversation and if she was here to visit (Resident A) that she needed to do that and stop harassing staff. I let her know that if she continues with the questions and yelling, she would be asked to leave the building. She then continued so I let her know that if she does not stop I would call the police. At that time, she said she would go into the room and shut the door. She did that but came right back out and left the building. This was all done in front of other residents."

I reviewed email correspondence sent to Relative A1. The email correspondence stated,

"This letter is to formally address ongoing behavioral concerns during your visits to Railside Assisted Living. Specifically, staff have reported incidents of unauthorized recording in hallways, confrontational behavior, and refusal to leave the premises or otherwise follow staff direction.
Effective immediately, visitation will only be permitted under the following conditions:
1. *No phones or recording devices are allowed in the building.*
2. *You must sign in at the front desk and be escort to and from the resident's room by a staff member. If no one is present at the front desk, you must call the building and have someone assist you.*
3. *Visitation must take place in the resident's room only.*
4. *Use the resident's call light to notify staff when you are ready to leave.*
5. *All questions or concerns regarding care must be directed to the court-appointed guardian.*
6. *You must interact with staff in a respectful and non-disruptive manner.*

7. *You must sign this letter acknowledging you understand and will abide by these regulations."*

APPLICABLE RULE	
MCL 333.20201	**Policy describing rights and responsibilities of patients or residents; adoption; posting; contents; additional requirements; discharging, harassing, retaliating, or discriminating against patient exercising protected right; exercise of rights by patient's representative; informing patient or resident of policy; designation of person to exercise rights and responsibilities; additional patients' rights; definitions.**
	(1) A health facility or agency that provides services directly to patients or residents and is licensed under this article shall adopt a policy describing the rights and responsibilities of patients or residents admitted to the health facility or agency. Except for a licensed health maintenance organization that is subject to chapter 35 of the insurance code of 1956, 1956 PA 218, MCL 500.3501 to 500.3573, the health facility or agency shall post the policy at a public place in the health facility or agency and shall provide the policy to each member of the health facility or agency staff. Patients or residents shall be treated in accordance with the policy.
For Reference: MCL 333.20201	**2) (k) A patient or resident is entitled to associate and have private communications and consultations with his or her physician or a physician's assistant to whom the physician has delegated the performance of medical care services, attorney, or any other person of his or her choice and to send and receive personal mail unopened on the same day it is received at the health facility or agency, unless medically contraindicated as documented in the medical record by the attending physician or a physician's assistant to whom the physician has delegated the performance of medical care services. A patient's or resident's civil and religious liberties, including the right to independent personal decisions and the right to knowledge of available choices, shall not be infringed and the health facility or agency shall encourage and assist in the fullest possible exercise of these rights. A patient or resident may meet with, and participate in, the activities of social, religious, and community groups at his or her discretion, unless medically contraindicated as documented in the medical**

	record by the attending physician or a physician's assistant.
ANALYSIS:	Interviews conducted and review of documentation revealed there are parameters for Resident A's family to visit Resident A. There is lack of evidence to support the allegation that Resident A's family is not allowed to visit Resident A.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A is not cared for.

INVESTIGATION:

The complainant alleged Resident A does not receive adequate care at the facility. The complainant alleged Resident A has aged many years in the short time she has been at the facility. The complainant alleged Resident A had a stye in her eye, and no medical attention was provided. The complainant alleged Resident A's feet are so swollen that she cannot walk.

On 07/28/2025, I interviewed SP2 at the facility. SP2 reported Resident A was admitted to the facility on 01/07/2025 from home. SP2 reported Resident A's feet are not swollen and never have been swollen. SP2 reported the facility has arranged for Resident A to have a walker to help with balance. SP2 reported Resident A is active with physical and occupational therapy. SP2 reported Resident A did have a stye in her eye and medication was started. SP2 reported if there are care concerns, the caregivers will bring them to the shift supervisor and then management. SP2 reported Resident A receives good care at the facility.

On 07/28/2025, I interviewed SP3 at the facility. SP3 reported Resident A receives good care at the facility. SP3 reported Resident A does use a walker for balance assistance. SP3 reported Resident A's feet are not swollen. SP3 reported caregivers are frequently in Resident A's room to assist her with care needs.

Resident A reported caregivers treat her well at the facility. Resident A reported no concerns with her feet. Resident A reported she is happy to be living at the facility.

I observed Resident A in her room. Resident A did have a walker, but she was able to ambulate with the walker. Resident A had clean clothes on, and care staff were getting ready to wash her hair.

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

“06/14/2025: (Resident A) has a stye in her right eye. SS was made aware.
06/14/2025: Doctor was called about her stye on her right eye. On-call nurse send message over to doctor so they are aware of it.
07/14: (Resident A) has a hard time walking. She holds on to the furniture as she walks. I’m afraid she is going to fall.
07/15: Her doctor ordered a walker awaiting delivery.”

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 and observations made revealed lack of evidence to support this allegation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A’s medications were not updated timely.

INVESTIGATION:

The complainant alleged Resident A’s blood glucose was to be checked twice daily and then it was changed to as needed. The complainant alleged this change did not occur for many weeks.

SP2 reported that when Resident A was admitted to the facility, Resident A’s blood glucose was to be checked twice a day. SP2 reported when the facility completed a new assessment, Resident A’s care needs had increased, and the family requested for the blood glucose checks to be discontinued. SP2 reported this was reflected in Resident A’s medicaiton administration record (MAR).

I reviewed Resident A’s MAR for May 2025. The MAR revealed Resident A had an order that read,
“Resident needs scheduled blood sugar checks. Please check blood sugar twice daily and as needed.”
This was completed twice daily 05/01/2025-05/29/205.

I reviewed an order from Resident A’s physician that was received on 05/19/2025. The order read,
“Please discontinued routine blood sugar checks twice a day. Please only check blood sugars a needed.”

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

"On 05/19/2025 at 2:05pm Physician Cheryl Kruithof NP ordered to discontinue taking daily glucose checks and continue only as PRN for (Resident A). (SP5) on duty did start order at 6:20pm on 05/19/2025."

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(2) Prescribed medication managed by the home shall be given, taken, or applied pursuant to labeling instructions, orders and by the prescribing licensed health care professional.
ANALYSIS:	Review of documentation revealed twice daily blood glucose checks were to be discontinued on 05/19/2025, however, this change did not occur until 05/29/2025.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Kimberly Horst 07/30/2025

Kimberly Horst Date
Licensing Staff

Approved By:

Andrea L. Moore 07/31/2025

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