



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 30, 2025

Jade Somes
Hearthside Assisted Living
1501 W. 6th Ave.
Sault Ste. Marie, MI 49783

RE: License #: AH170271455
Investigation #: 2025A1035082
Hearthside Assisted Living

Dear Jade Somes:

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 responsible party and a date.

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,

Jennifer Heim, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
Lansing, MI 48909
(313) 410-3226
enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH170271455
Investigation #:	2025A1035082
Complaint Receipt Date:	08/06/2025
Investigation Initiation Date:	08/06/2025
Report Due Date:	10/06/2025
Licensee Name:	Superior Health Support Systems
Licensee Address:	Suite 120 1501 W. 6th Ave. Sault Ste. Marie, MI 49783
Licensee Telephone #:	(906) 632-9886
Administrator:	Jade Somes
Authorized Representative:	Tracey Holt
Name of Facility:	Hearthside Assisted Living
Facility Address:	1501 W. 6th Ave. Sault Ste. Marie, MI 49783
Facility Telephone #:	(906) 635-6911
Original Issuance Date:	08/01/2006
License Status:	REGULAR
Effective Date:	08/01/2025
Expiration Date:	07/31/2026
Capacity:	64
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Facility has a disorganized program. Resident A is not receiving care in accordance with service plan.	No
Facility does not have enough care staff to meet the needs of the residents.	Yes
Resident A is not receiving medications as ordered.	No
Additional Findings	No

III. METHODOLOGY

08/06/2025	Special Investigation Intake 2025A1035082
08/06/2025	Special Investigation Initiated - Letter
08/12/2025	Contact - Face to Face
08/20/2025	Contact - Telephone call received phone interview with Family A
08/21/2025	Contact - Telephone call received complainant contacted to voice additional concerns.
10/06/2025	Contact – Additional requested information received.
10/06/2025	Contact – Phone interview conducted with Tracey Holt Administrator.
10/30/2025	Inspection Complete. BCAL Non-Compliance.
10/30/2025	Exit Conference.

ALLEGATION:

Facility has a disorganized program. Resident A is not receiving care in accordance with service plan.

INVESTIGATION:

On August 6, 2025, the Department received a complaint forwarded from Adult Protective Services (APS) which read:

“Unknown staff marked that client had been changed and showered when they were not. There are concerns that Resident A. is being abused. Resident A. is being left in diapers filled with urine. Resident A. has ulcers on her feet. A few months ago, Resident A had a bruised ear and black eye, and it was stated that Resident A had fallen. Resident A is walking around although she has ulcers on her feet. Saturday, Resident A had the same clothes and diaper on from the day before.”

On August 20, 2025, a phone interview was conducted with Family A. Family A stated, “there is never enough help, the manager covers up incidents, and the facility failed to reorder and pick up Resident A’s medications.” Family A stated there was an incident where a staff member “spit” in Resident A’s face and the facility “covered it up.”

On September 12, 2025, an onsite investigation was conducted. While onsite I interviewed staff person (SP)1 who states the facility has been working with Resident A and Family A to meet the needs of Resident A. SP1 states Resident A had poor safety awareness and became combative at times.

Through record review progress notes and service plan indicate Resident A becomes combative and refuses care. The facility has made notation of contacting family to come in and assist with resident and her behaviors. Progress notes indicate Resident A receives wound care services through an external provider. Facility nurse has documented heel assessments on multiple accounts throughout the months reviewed. The facility was able to provide documentation within the progress notes and incident accident reports related to fall occurrences. Facility was able to provide documentation related to the incident Family A stated. Facility followed policy and took disciplinary action.

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:	Through record review Resident A is receiving care in accordance with her service plan. Additionally, the facility took appropriate action to address the incident of concern.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Facility does not have enough care staff to meet the needs of the residents.

INVESTIGATION:

On August 6, 2025, the Department received a complaint forwarded from Adult Protective Services (APS) state concerns related to the facility being short-staffed.

On August 20, 2025, a phone interview was conducted with Family A. Family A stated, "there is never enough help."

On September 12, 2025, an onsite investigation was conducted. While onsite, I interviewed staff person (SP)1 who states the facility staff in accordance to resident census and the acuity of the residents.

On October 6, 2025, Tracey Holts Administrator stated average daily census is "capped at 55 with average around 52. No less than 3 aides on the floor with a goal of 4."

On October 6, 2025, a phone interview was conducted with SP1 who states the facility continues to interview and employee new staff.

Through record review of staffing schedule August 1st through August 16th days and afternoon shift staffed according to stated staffing plan of minimum of 3 aides. Midnight shift staffed primarily with one shift supervisor and one aide. August 18th appears to have had one aide assigned to the midnight shift.

APPLICABLE RULE	
R 325.1931	Employees; general provisions.
	(5) The home shall have adequate and sufficient staff on duty at all times who are awake, fully dressed, and capable of providing for resident needs consistent with the resident service plans.

ANALYSIS:	Through record review of staffing schedule August 1 st through August 18 th the facility had scheduled two staff members on the midnight shift for the average daily census of 52. Based on information noted above this allegation has been substantiated.
CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION:

Resident A is not receiving medications as ordered.

INVESTIGATION:

On August 6, 2025, the Department received a complaint forwarded from Adult Protective Services (APS) which read:

“Missed medication. Staff did not order the medication ahead of time so client ran out.”

On August 20, 2025, a phone interview was conducted with Family A. Family A stated, “the facility failed order and to pick up Resident A’s medications.”

While onsite I interviewed SP1 who states the facility is not responsible for picking up medications. In the event a medication is needed that the pharmacy does not provide, it is the responsibility of the POA to facilitate the delivery.

Through record review of medication administration record (MAR) of July and August medication had been administered as ordered.

APPLICABLE RULE	
R 325.1932	Resident medications.
	(1) Medication shall be given, taken, or applied pursuant to labeling instructions or orders by the prescribing licensed health care professional.
ANALYSIS:	Through record review medications have been administered as ordered.
CONCLUSION:	VIOLATION NOT ESTABLISHED

IV. RECOMMENDATION

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



10/06/2025

Jennifer Heim, Health Care Surveyor Date
Long-Term-Care State Licensing Section

Approved By:



10/30/2025

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