



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 31, 2026

Lauren Gowman
Bay Ridge Assisted Living
3825 Scenic Ridge
Traverse City, MI 49684-3900

RE: License #: AH280318130
Investigation #: 2026A1021031
Bay Ridge Assisted Living

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 #:	AH280318130
Investigation #:	2026A1021031
Complaint Receipt Date:	03/12/2026
Investigation Initiation Date:	03/13/2026
Report Due Date:	05/11/2026
Licensee Name:	Bay Ridge Assisted Living Ctr, LLC
Licensee Address:	950 Taylor Ave Grand Haven, MI 49417
Licensee Telephone #:	Unknown
Administrator:	Kelly Ofarrell
Authorized Representative:	Lauren Gowman
Name of Facility:	Bay Ridge Assisted Living
Facility Address:	3825 Scenic Ridge Traverse City, MI 49684-3900
Facility Telephone #:	(231) 932-9757
Original Issuance Date:	05/15/2012
License Status:	REGULAR
Effective Date:	08/01/2025
Expiration Date:	07/31/2026
Capacity:	64
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A's care needs are not met.	Yes
Additional Findings	Yes

III. METHODOLOGY

03/12/2026	Special Investigation Intake 2026A1021031
03/13/2026	Special Investigation Initiated - Letter correspondence with APS worker
03/23/2026	Inspection Completed On-site
03/24/2026	Contact-Documents Received Received Resident A documents
03/31/2026	Exit Conference

The complainant identified some concerns that were not related to home for the aged licensing rules and statutes. Therefore, only specific items pertaining to homes for the aged provisions of care were considered for investigation. The following items were those that could be considered under the scope of licensing.

ALLEGATION:

Resident A's care needs are not met.

INVESTIGATION:

On 03/12/2026, the licensing department received a complaint from Adult Protective Services (APS). The APS reporting source alleged that when Resident A speaks out about staff, Resident A will find coffee grounds in her coffee that are not removed. The APS reporting source alleged that Resident A was left in a cold shower for approximately 45 minutes. The APS reporting source alleged that items were taken out of Resident A's room because of comments Resident A made regarding wanting to kill herself.

On 03/13/2026, health care surveyor Tammie Daniels and I interviewed Resident A at the facility. Resident A reported the food is not good and there have been issues with food not available. Resident A reported at times that the food is not chopped

when it is brought to her. Resident A reported at times that the water temperature in the shower room is not hot. Resident A reported in June 2025, she was left in the shower for approximately 45 minutes. Resident A reported care staff are to transfer her into the shower and return seven minutes later to assist her out of the shower. Resident A reported on this incident, the care staff did not return for a long period of time, and she could not ring for assistance. Resident A reported a while ago, she was very upset with the food and not getting sleep at the facility. Resident A reported she told a care member that she would kill herself if she had to eat another meal. Resident A reported she was upset and did not mean to say this statement. Resident A reported after this statement was made, a war pin and knife were taken out of her room, and her family had to get the items from management which they did. Resident A reported she was put on frequent checks and care staff would come in during sleeping hours to check on her.

On 03/23/2026, we interviewed staff person 1 (SP1) at the facility. SP1 reported that Resident A requires assistance with transfers in and out of the shower, but that Resident A can bath herself. SP1 reported care staff are to transfer Resident A and then return eight minutes later. SP1 reported on this incident the care staff got pulled away and Resident A was left in the shower for 15 minutes. SP1 reported that there were some issues with kitchen staff but there was always food available to the residents. SP1 reported no knowledge of food items not being available. SP1 reported that Resident A did make a statement on wanting to kill herself and she was placed on increased checks. SP1 reported these increased checks are now discontinued.

On 03/23/2026, we interviewed SP2 at the facility. SP2 reported that prior to his employment there were some issues with keeping kitchen staff. SP2 reported there was always food available to the residents. SP2 reported that if a food item was not available, staff could purchase the item from the local grocery store. SP2 reported that Resident A's food is to be chopped.

On 03/23/2026, we viewed the kitchen at the facility. In the kitchen there was plenty of food items available to the residents. I viewed the lunch meal service, and it appeared to be adequate in food variety and quantity.

On 03/23/2026, we viewed the shower room at the facility. The water temperature was within normal range. The shower was a walk-in shower with no pull cord available in the shower. The only pull cord in the shower was located near the toilet in the shower room.

We reviewed Resident A's service plan. The service plan read,

"I need one staff member to assist me with all of my showering and bathing. Requires full assistance including physical and verbal assistance. Requires hand-on assistance with washing, shampooing, and getting in and out of tub/shower. I am on a regular diet with no restrictions."

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 Resident A requires food to be chopped. Also, Resident A does not require assistance with showering, only the transfer in/out of the shower. Review of Resident A's service plan revealed this information was not detailed in the service plan.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

Resident A and SP1 reported Relative A1 is not allowed to visit the facility.

On 03/23/2026, we interviewed the administrator Kelly Ofarrell at the facility. The administrator reported that the facility scheduled a care conference regarding the care needs of Resident A. The administrator reported that during the care conference Relative A1 became very upset and started to yell at management. The administrator reported that the police were called. The administrator reported Relative A1 is no longer able to come to the facility.

We reviewed the facility visitor policy in the facility handbook. The policy read,

"Your family and friends may visit you any time you desire. You are responsible for all guests and visitors when they are visiting, for seeing that they comply with the homes' rules and regulations, and that they do not disturb other residents."

APPLICABLE RULE	
MCL 333.20201	Policy describing rights and responsibilities of patients or residents; adoption; posting and distribution; 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.

	<p>(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, which shall comply with chapter 35 of the insurance code of 1956, 1956 PA 218, MCL 500.3501 to 500.3580, the policy shall be posted at a public place in the health facility or agency and shall be provided to each member of the health facility or agency staff. Patients or residents shall be treated in accordance with the policy.</p>
<p>For Reference: MCL 333.20201</p>	<p>(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.</p>
<p>ANALYSIS:</p>	<p>Interviews conducted and documents reviewed revealed the facility is limiting Relative A from visiting Resident A at the facility. The attending physician has not documented in the record that these visits are medically contraindicated. Resident A has a right to associate with any person of her choice and this right has not been ensured as this law requires.</p>
<p>CONCLUSION:</p>	<p>VIOLATION ESTABLISHED</p>

IV. RECOMMENDATION

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

Kimberly Horst

03/30/2026

Kimberly Horst
Licensing Staff

Date

Approved By:

Andrea Moore

03/31/2026

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

Date