GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

September 4, 2020

Anna Hinton
Pioneer Resources
Suite 100
601 Terrace St.
Muskegon, MI 49440

RE: License #:	AS610237359
Investigation #:	2020A0356050
	Riverwood

Dear Ms. Hinton:

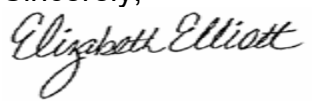
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.

If you desire technical assistance in addressing these issues, please 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. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,



Elizabeth Elliott, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 901-0585

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS610237359
Investigation #:	2020A0356050
Complaint Receipt Date:	07/27/2020
Investigation Initiation Date:	07/27/2020
Report Due Date:	09/25/2020
Licensee Name:	Pioneer Resources
Licensee Address:	Suite 100, 601 Terrace St. Muskegon, MI 49440
Licensee Telephone #:	(231) 773-5355
Administrator:	Anna Hinton
Licensee Designee:	Anna Hinton
Name of Facility:	Riverwood
Facility Address:	2743 S Riverwood Twin Lake, MI 49457
Facility Telephone #:	(231) 773-5355
Original Issuance Date:	08/08/2001
License Status:	REGULAR
Effective Date:	02/20/2020
Expiration Date:	02/19/2022
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A complained of pain in his arm for several days before medical attention was sought.	Yes

III. METHODOLOGY

07/27/2020	Special Investigation Intake 2020A0356050
07/27/2020	Special Investigation Initiated - Telephone Margaret Tietze, Office of Recipient Rights.
07/27/2020	Contact - Document Received IR's
07/27/2020	Contact - Document Received Medical documentation.
07/28/2020	APS Referral Assigned for investigation to Ken Beckman.
07/28/2020	Contact - Telephone call made Kara Kile, Supports Coordinator, HealthWest.
07/29/2020	Contact - Face to Face Margaret Tietze, Larry Spataro ORR and Anna Hinton, LD, interviews with DCW's Crystal Bell, Felicia Young, Nicole Manley, Alicia Grider, Jeff Taylor, Moran Taylor, Latrell Williams, Darlesha Vines.
07/30/2020	Contact - Telephone call made Kara Kile, HealthWest Supports Coordinator.
07/31/2020	Contact - Document Received Resident A facility documents sent by A. Hinton, LD.
09/04/2020	Exit Conference- Licensee Designee, Anna Hinton

ALLEGATION: Resident A complained of pain in his arm for several days before medical attention was sought.

An onsite inspection at this facility was not conducted due to COVID19 restrictions. Interviews were conducted via Zoom meeting.

INVESTIGATION: On 07/27/2020, I received a Recipient Rights Complaint sent to me from Muskegon County HealthWest (Community Mental Health) Office of Recipient Rights. The complainant documents the following information, '*Please see the attached IR's (incident reports) from 06/22/2020, 06/23/2020 and 06/27/2020. (IR's received 7/15/2020). These IR's stated that* (Resident A) *was complaining of pain in his arm starting on 06/22/2020.* (Resident A) *was diagnosed with a broken arm on 06/27/2020.'*

On 07/27/2020, I received and reviewed an IR dated 06/22/2020 (Monday), written by DCW (Direct Care Worker) Alicia Grider. The IR documents the following, *'(Resident A) asked to use the bathroom when I told him to get up he said he couldn't get up and his arm was just hanging. He couldn't walk or stand up at all. He couldn't put his close [sic] on or even get in bed. He was just not himself at all and he keep saying his arm hurt real bad.'* At the bottom of the IR, Licensee Designee, Anna Hinton documented on 07/15/2020, *'It appears that reporting staff did not contact anyone about this issue. I am reviewing other documentation to see if any action was taken. I will also post a memo reminding staff of reporting requirements.'*

On 07/27/2020, I received and reviewed an IR dated 06/23/2020 (Tuesday), written by DCW Crystal Bell and names Darlisha Vines as the other DCW on duty on this date. The IR documents the following, *'(Resident A) unable to stand on his own. Right side of his body limp. Repetitive speech. Used the RR (rest room) on self.' At the bottom of the IR, Ms. Hinton documented on 07/15/2020, 'It appears that reporting staff did not contact anyone about this issue. I am reviewing other documentation to see if any action was taken. I will also post a memo reminding staff of reporting requirements.'*

On 07/27/2020, I received and reviewed an IR dated 06/27/2020 (Friday), written by Moran Taylor, Home Assistant and names Alicia Grider and Crystal Bell as the DCW's on duty. The IR documents the following, *'Staff notices (Resident A's) arm swollen, called the nurse was asked to call on call take to ER. On call was called to take (Resident A) to ER. 911 was call to transport's once there found out his right arm was broken upper arm was put in sling and discharged need to see specialist. Hackley Hospital.'* Ms. Hinton documented on 07/13/2020, *'Moran Taylor, Home Assistant took (Resident A) to the ER, and I believe she wrote this IR, but didn't sign. Doctors orders to be followed. (Resident A) will be scheduled to see specialist for possible surgery.'*

On 07/27/2020, I received and reviewed medical documents from Mercy Health Hackley Campus dated 06/27/2020. The attending provider is Dr. Seth Jaskowiak, MD. Resident A's date of birth is documented as 05/17/1944 and Resident A's '*impression: No acute cardiopulmonary abnormality, diffuse osteopenia, Comminuted and mildly displaced, angulated fracture of the right proximal humerus diaphysis, there is lateral apex angulation at the fracture site, fracture is mildly displaced with the distal fracture fragment displaced medially by on half shaft width, AC joint is intact.'* The report further documents, '*76-year-old white male with profound cognitive impairment and seizure disorder presents with his caretaker from his AFC home with right arm injury. Unsure of how or when it happened. He is able to walk with assistance however no falls were reported. He typically gets around in a wheelchair. While he is resting in his wheelchair he tends to lean on that right humerus. Also when upset he tends to bang the wall with his right fist. It not really clear exactly how or why the injury occurred however third shift came in today and reevaluated the arm and noticed it was swollen and bruised. No other injuries elsewhere noted. While at rest he does not seem uncomfortable. However, when manipulating that arm he shouts and yells and sign of pain. Unaided little to determine pain scale due to his profound cognitive impairment. Typically, he speaks yes or no only. No signs of injuries or concerns of any injuries elsewhere.'*

On 07/29/2020, Margaret Tietze, Larry Spataro, Office of Recipient Rights Advocates through HealthWest and Ms. Hinton, Licensee Designee interviewed DCW Crystal Bell. Ms. Tietze, Mr. Spataro and Ms. Hinton were face-to-face, and I joined via zoom meeting (face-to-face via camera). Ms. Bell stated she was off from work for 5-6 days and came back to work on 06/23/2020 and worked with DCW Darlisha Vines. Ms. Bell stated she and Ms. Vines worked 3rd shift and she noticed during her shift that Resident A's arm was bruised on the inside of his right upper arm. Ms. Bell stated Resident A would not move his arm at all and she asked Ms. Vines if she knew what was wrong with Resident A's arm. Ms. Bell stated Ms. Vines didn't know either. Ms. Bell stated she wrote an IR and saw, in the mailbox for the home manager, Cindy Morden (who is out on a medical leave) another IR that someone had written. Ms. Bell stated she noticed Resident A's leg was more swollen and there was no movement of Resident A's right side. Ms. Bell stated Resident A typically will go to the bathroom, shower and get out of his bed or chair on his own but on this date, he refused to go to the bathroom or get up on his own. Ms. Bell stated Resident A does fall and it is not out of the ordinary for Resident A to have a fall. Ms. Bell explained that she and Ms. Vines had to get Resident A up together by standing on both sides of him and using his belt loops on his pants and his "good arm" (on his left side) to assist him in getting up. Ms. Bell stated that is not normal or typical of how Resident A normally is. Ms. Bell stated when she began her shift, the second shift DCWs said to watch Resident A because something wasn't right with him. Ms. Bell stated no one knows what happened to Resident A's arm and Resident A is unable to tell anyone (other than it hurts) due to his cognitive delays. Ms. Bell stated she wrote an IR but did not contact anyone because she never contacts anyone, when she writes the IR, she lets 1st shift staff know and then hopes the IR is read by "whomever does that." Ms. Bell stated she told Ms. M. Taylor

the IR's were in the box on 06/23/2020 (in a mailbox located in the facility). Ms. Bell stated the following night she worked, 06/24/2020 (Tuesday) and Resident A was the same way, he was still acting the same as he did on 06/23/2020 (Monday). Ms. Bell stated when she then came back to work on Friday, 06/27/2020 and Resident A was still in the home and had not been to the emergency room, "I couldn't believe it" so that night, Friday night, she and Ms. Vines called the on-call nurse who instructed them to call 911 and have Resident A go to ER. Ms. Bell stated staff look to the Home Assistant, Ms. M. Taylor for instructions on what to do in these types of situations but this time, "we went above Moran's (Ms. M. Taylor) head" and called the on-call nurse" since Resident A had been like this for days. Ms. Bell stated when EMS arrived, they said immediately that Resident A's arm was broken and asked, "when did he fall?" Ms. Bell stated she saw no IR's documenting a fall and Resident A could not tell us if he fell or what happened.

On 07/29/2020, Mr. Spataro, Ms. Tietze, Ms. Hinton and I interviewed DCW Felicia Young. Ms. Young stated she works 1st shift at the facility and worked every day from 06/20/2020-06/27/2020. Ms. Young stated when Resident A doesn't feel well, he is resistant to care, and all week Resident A was resistant to care. Ms. Young stated Resident A slept in his recliner all week and she noticed all his weight was on his right arm and he'd say, "it hurts." Ms. Young stated when staff help Resident A up, they pull him by his hands to get him up and that is probably how he got injured. Ms. Young stated when she assists Resident A up and out of his chair, she assists him on his left side and lifts him under his arm. Ms. Young stated normally, Resident A goes to his room and sleeps in his bed but during this week, 06/20/2020-06/27/2020 he slept in his recliner chair. Ms. Young stated Resident A was using his right arm and showed no signs that he couldn't use the right arm. Ms. Young stated a couple of days before Resident A went to the ER, she noticed Resident A's "arm issue" that is was swollen but he was still using the arm, he was eating on his own and she was surprised when he went to the ER and his arm was broken. Ms. Young stated she didn't think much of Resident A's arm being swollen because his arms and legs are often swollen so that was not unusual. Ms. Young stated when Resident A came back from the hospital with a sling on his arm is when she knew something was actually really wrong with his arm, prior to that, she didn't think there was anything wrong with him.

On 07/29/2020, Mr. Spataro, Ms. Tietze, Ms. Hinton and I interviewed Nicole Manly, 1st shift DCW. Ms. Manly stated she worked 1st shift on Monday, 06/22/2020 and Resident A was in his bed and needed assistance getting up and out of bed, he called out for staff to help him. Ms. Manly stated she noticed his right arm was "weak" and he could not feed himself as he normally did, he could drink coffee with his left hand but needed help eating on his right. Ms. Manly stated she worked on Friday, 06/20/20 and Resident A was fine on that date and when she returned on Monday, 06/22/2020, Resident A was like this, not normal, unable to get up and needed help. Ms. Manly stated staff fed Resident A on 06/22/2020, Latrell (DCW) fed him on Tuesday, 06/23/2020 and Felicia (DCW) fed him one day too. Ms. Manly stated, on Tuesday, 06/23/2020 when she worked 1st shift, Resident A needed help

getting up again and so she called Ms. M. Taylor, the home assistant to report and called the HealthWest on call nurse and was instructed to give Resident A Tylenol (Ms. Manly does not know the name of the on call nurse she spoke to). Ms. Manly stated she did not think anything was really wrong with Resident A's arm so she may not have described his injury/ailment in a way the nurse thought would need ER attention. Ms. Manly stated on Thursday, 06/26/2020, Resident was the same way and she thought he should go to the doctor but she (Ms. Manley) does not make any medical appointments. Ms. Manley stated she thought Ms. M. Taylor was going to make an appointment.

On 07/29/2020, Mr. Spataro, Ms. Tietze, Ms. Hinton and I interviewed DCW Alicia Grider. Ms. Grider stated she is a 3rd shift DCW at the facility and she worked Monday 06/22/2020, Thursday 06/25/2020 and Friday 06/26/2020. Ms. Grider stated on Monday 06/22/2020, she noticed that Resident A wasn't himself, his whole arm looked like it was hanging, and no one knew when it happened or what happened. Ms. Grider stated Resident A's arm was swollen and bruised, she said she was so upset she cried about it, wrote an IR and told Ms. M. Taylor and DCW Dominique Thomas something was wrong with Resident A's arm. Ms. Grider stated she came back on Thursday 06/25/2020 and Resident A was worse. Ms. Grider stated she questioned everyone, and they said they wrote IR's (Crystal Bell, Dominique Thomas and Darlisha Vines) so Ms. Grider stated Ms. M. Taylor knew something was wrong because everyone else thought something was wrong. Ms. Grider stated she told Ms. M. Taylor she was going to stay over extra and take Resident A to the hospital and Ms. M. Taylor responded to her by saying, "oh, he's ok" but Ms. Grider stated Resident A wasn't doing anything on his own like usual. Ms. Grider stated by Friday 06/26/2020, she called the on-call nurse (possibly her name was Robin) gave her Resident A's symptoms and the on-call nurse instructed her (Ms. Grider) to have Resident A taken to the hospital. Ms. Grider stated she then called Ms. M. Taylor who "cussed her out and said, this is some bullshit, now I gotta stop what the fuck I'm doing to take him to the hospital." Ms. Grider stated Ms. M. Taylor called EMS (emergency medical services) and when they arrived, EMS stated, "his arm is broken" and it looks like it had been that way "for a while, this didn't just happen." Ms. Grider stated Ms. M. Taylor stated she did not know what happened and that he was fine when she was at the facility.

On 07/29/2020, Mr. Spataro, Ms. Tietze, Ms. Hinton and I conducted an interview via telephone with DCW Jeff Taylor. Mr. J. Taylor stated he worked 3 days the week of 06/22/2020 on second shift and didn't notice anything different with Resident A until 06/25/2020, Resident A kept asking for help, Resident A usually gets up on his own, but he kept asking staff for help to get up which was not like him. Mr. J. Taylor stated prior to 06/25/20202, Resident A was eating on his own but on 06/25/2020, Resident A refused to eat on his own and was asking staff to assist him with eating. Mr. J. Taylor stated he noticed Resident A's arm was bruised and reddish in color. Mr. J. Taylor stated he asked other staff what happened to Resident A's arm and they told him that 3rd shift wrote an IR about his arm, but no one knew what had happened.

On 07/29/2020, Mr. Spataro, Ms. Tietze, Ms. Hinton and I interviewed Moran Taylor. Ms. M. Taylor described her job title as resident support staff and on call support staff. Ms. M. Taylor stated she works Monday through Friday, daytime hours. Ms. M. Taylor stated Resident A "appeared to be fine" the entire week prior to going to the hospital yet, Ms. M. Taylor stated she consulted with the HealthWest nurse LaSonya Fondren at some point prior to Resident A going to the hospital, because of staff concerns. Ms. M. Taylor stated Ms. Fondren instructed her to give Resident A Tylenol and to monitor Resident A but Ms. M. Taylor does not recall what date she did this. Ms. M. Taylor stated she did not see anything unusual or notice anything different about Resident A throughout the week of 06/22/2020-06/27/2020. Ms. M. Taylor stated she asked staff if they noticed anything different with Resident A, was he standing, was he eating, and all the staff stated he was doing everything as he normally did. Ms. M. Taylor stated during the week of 06/22/2020-06/27/2020, Resident A did not need help getting out of his chair except for one time when Ms. M. Taylor reported he needed assistance, so she put her hands out, he grabbed her hands and pulled himself up. Ms. M. Taylor stated Resident A is unsteady on his feet and has an alarm on his bed and chair, so staff are made aware of when he is getting to his feet as he is unsteady. Ms. M. Taylor stated staff told her Resident A was sleeping in his chair and "leaning on his arm" but this is not out of the ordinary for Resident A. Ms. M. Taylor stated she received a telephone call from Ms. Grider during 3rd shift on 06/26/2020-06/27/2020 saying Resident A's arm was swollen and his arm is "this and that" so she (Ms. M. Taylor) began calling the on call nurse through HealthWest and got not answer so she left a message. Ms. M. Taylor stated she then called 911 for an ambulance to take Resident A to ER since he refused to get into the facility van. Ms. M. Taylor acknowledged that IR's were written, 2 by staff and the 3rd one was written by her (Ms. M. Taylor) and one staff, Ms. Grider reported verbally that there was something wrong with Resident A's arm. Ms. M. Taylor stated the 2 staff IR's were written and placed in a blue envelope in the home manager's mailbox, which is protocol; however, the home manager is out on sick leave, so Ms. M. Taylor stated she did not see the IR's until the evening of 06/26/2020 or the morning of 06/27/2020.

On 07/29/2020, Mr. Spataro, Ms. Tietze, Ms. Hinton and I interviewed DCW Latrell Williams. Ms. Williams stated she worked 06/22,06/23,06/24 and 06/25/2020, she is not sure which date it was, but she was working 1st shift with Ms. Manly when Ms. Manly said Resident A could not get up on his own so she (Ms. Williams) got Resident A up, dressed and went on with the day but Resident A said his arm hurt but he was stilling moving it. Ms. Williams stated Ms. Manly called and talked to an on-call nurse who said to give Resident A Tylenol. Ms. Williams stated she does not know who the nurse was but Ms. Manly called and spoke to a nurse. Ms. Williams stated she checked Resident A's arm at one point during the days she worked and did not see any swelling or bruising on Resident A's arm. Ms. Williams stated Resident A did not have any falls or seizures during her shifts, she knew of nothing that had occurred that could have injured Resident A's arm. Ms. Williams stated staff did not talk about Resident A's arm being injured and she did not write an IR but did refer to Ms. Moran Taylor that Resident A needed assistance with feeding on the

days she worked because he could not do it on his own. Ms. Williams stated Ms. M. Taylor instructed her to consult the on-call nurse.

On 07/29/2020, Mr. Spataro, Ms. Tietze, Ms. Hinton and I interviewed DCW Darlisha Vines. Ms. Vines stated she worked Friday, 06/19/2020, 3rd shift and had Saturday, 06/20/2020 and Sunday, 06/21/2020 off. Ms. Vines stated she returned to work on Tuesday night, 06/23/2020 and worked with Ms. Bell and that is when she noticed that Resident A was unable to get up or get to the bathroom on his own. Ms. Vines stated the week prior, 06/15/2020-06/19/2020, Resident A was fine when she worked. Ms. Vines stated on 06/23/2020, Resident A could not help staff at all like he normally did, Ms. Bell wrote an IR and noticed that another IR had been written also. Ms. Vines stated the following day, 06/24/2020, Ms. Bell called Ms. M. Taylor and informed her that something was wrong with Resident A. Ms. Vines stated Ms. M. Taylor acknowledged the information and said she was on her way out the door, Ms. Vines stated she does not know if Ms. M. Taylor did anything with the information Ms. Bell had reported to her. Ms. Vines stated she worked again on Wednesday, 06/24/2020 and asked about Resident A, when she found out he was still at the facility, she was “surprised,” and Mr. J. Taylor told her (Ms. Vines) that he had to feed Resident A, which was unusual. Ms. Vines stated when she came back to work on Saturday, 06/27/2020, Mr. J. Taylor informed her that Resident A’s arm was broken because when Ms. Grider came back to work, she called the on-call nurse and that is how Resident A finally got help.

On 07/29/2020, I received and reviewed Consumer Progress Notes written by staff daily to inform other shift staff about things that went on during each shift. On 06/21/2020, 10:30P-6:30A 3rd shift staff documented that Resident A said his arm hurt, on 06/23/2020, 10:30P-6:30A 3rd shift staff documented that Resident A couldn’t stand on his own, is left side is swollen and limp, on 06/26/2020, 6:30A 1st shift staff documented that the only concern was that Resident A kept complaining about his arm and on 06/26/2020, 10:30P-6:30A (06/26/2020 to 06/27/2020) 3rd shift staff documented that Resident A’s arm was swollen ‘*really bad,*’ and Resident A went to the ER and came back to the facility approximately 3:00AM.

On 07/30/2020, I interviewed Kara Kile, Supports Coordinator with HealthWest via telephone. Ms. Kile stated Ms. Fondren, nurse contacted her on 06/29/2020 to inform her that Resident A went to the hospital and his arm was broken just below the shoulder. Ms. Kile stated Resident A does fall and she assumed he fell and broke his arm. Ms. Kile stated Resident A is not able to tell anyone how he broke his arm, but he is capable to telling staff that his arm hurt. Ms. Kile stated she requested the IR’s from the facility for the hospital visit and when she got 3 different IR’s dating back to 06/22/2020 so staff noticed something wrong with Resident A’s arm a delay in care was apparent.

On 09/04/2020, I conducted an Exit Conference with Licensee Designee, Anna Hinton. Ms. Hinton stated she has already begun to address the issue of reporting with staff and will continue to train staff about their duty to report all concerns

regarding residents health care. Ms. Hinton stated she will submit an acceptable corrective action plan.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.
ANALYSIS:	Based on investigative findings, there is a preponderance of evidence to show that Resident A began exhibiting symptoms and complaining of pain in his right arm on 06/22/2020 with various staff documenting and reporting that Resident A was complaining of arm pain. However, medical care was not sought until 06/27/2020 when Resident A was sent to the emergency room and it was determined that he had a fracture of the right humerus. Therefore, it is established that upon Resident A's adverse change in physical condition, care was not sought immediately, and a violation of this applicable rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

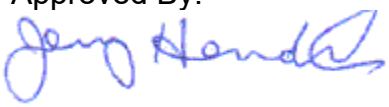
IV. RECOMMENDATION

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

09/04/2020

Elizabeth Elliott Date
Licensing Consultant

Approved By:



09/04/2020

Jerry Hendrick Date
Area Manager