



STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

GRETCHEN WHITMER  
GOVERNOR

ORLENE HAWKS  
DIRECTOR

January 29, 2021

Paul Wyman  
Retirement Living Management of Fruitport  
1845 Birmingham  
Lowell, MI 49331

RE: License #:	AM610397644
Investigation #:	2021A0356018
	Chestnut Fields Retirement Community

Dear Mr. Wyman:

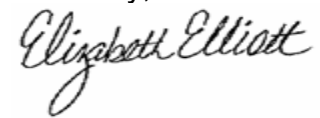
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 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. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

A handwritten signature in cursive script that reads "Elizabeth Elliott". The signature is written in black ink and is positioned below the word "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**

<b>License #:</b>	AM610397644
<b>Investigation #:</b>	2021A0356018
<b>Complaint Receipt Date:</b>	01/19/2021
<b>Investigation Initiation Date:</b>	01/19/2021
<b>Report Due Date:</b>	03/20/2021
<b>Licensee Name:</b>	Retirement Living Management of Fruitport
<b>Licensee Address:</b>	1845 Birmingham Lowell, MI 49331
<b>Licensee Telephone #:</b>	(616) 897-8000
<b>Administrator:</b>	Nicole Bradley, Administrator
<b>Licensee Designee:</b>	Paul Wyman, Designee
<b>Name of Facility:</b>	Chestnut Fields Retirement Community
<b>Facility Address:</b>	5467 Chestnut Drive Muskegon, MI 49444
<b>Facility Telephone #:</b>	(231) 798-2220
<b>Original Issuance Date:</b>	08/22/2019
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	02/22/2020
<b>Expiration Date:</b>	02/21/2022
<b>Capacity:</b>	12
<b>Program Type:</b>	AGED ALZHEIMERS

## II. ALLEGATION(S)

	<b>Violation Established?</b>
Staff Cherry Quijano disclosed to another staff Shelby Souza, that she slapped Resident A.	Yes

## III. METHODOLOGY

01/19/2021	Special Investigation Intake 2021A0356018
01/19/2021	APS Referral Gene Gray, Muskegon Co. APS, DHHS.
01/19/2021	Special Investigation Initiated - Telephone Nicole Bradley, Administrator.
01/19/2021	Contact - Document Received Incident Report (IR).
01/19/2021	Contact - Telephone call received. Nicole Bradley and staff, Shelby Souza.
01/19/2021	Contact - Telephone call made. Former staff Kylie Pimenta and Cherry Quijano.
01/19/2021	Contact - Telephone call made. Fruitport Police-police report not completed yet.
01/19/2021	Contact - Telephone call received. Kylie Pimenta, former staff.
01/20/2021	Contact - Document Received Facility documents received.
01/20/2021	Contact - Telephone call received. Nicole Bradley and Shelby Souza.
01/22/2021	Contact - Document Received Facility documents received.
01/25/2021	Contact - Telephone call made. Ruth Baxter and Charity Baxter, staff at the facility.

01/25/2021	Contact - Document Sent Doc sent and received, Fruitport Township Police Dept. report.
01/28/2021	Exit Conference Amber Fry as approved by LD, Paul Wyman.

**ALLEGATION: Staff Cherry Quijano disclosed to another staff Shelby Souza, that she slapped Resident A.**

**INVESTIGATION:** On 01/19/2021, I received a BCAL (Bureau of Children and Adult Licensing) Online Complaint. The complainant reported that Cherry Quijano is a direct care worker (DCW) at the facility and recently disclosed to another staff that she has hit Resident A in the past. The complainant reported Ms. Quijano said she hit Resident A because Resident A was hitting her and that's why Resident A no longer hits her but continues to hit other staff. The complainant reported it is unknown when this occurred. The complainant reported today, Resident A had a complete body audit but there was no evidence of abuse, only two small bruises on her lower extremities. On today's date, there will be a meeting held with Ms. Quijano and she will be terminated from her employment at the facility. Muskegon County Department of Health and Human Services, Adult Protective Service Worker (APS) Gene Gray has been assigned to investigate.

On 01/19/2021, I interviewed Nicole Bradley, Administrator and DCW Shelby Souza via telephone. Ms. Souza stated when they were working together on 01/16/2021, Ms. Quijano told her that Resident A was going after former staff Kylie Pimenta pulling her hair and slapping her, so she (Ms. Quijano) slapped Resident A on the hands on two different occasions to get Resident A to stop hitting Ms. Pimenta. Ms. Souza stated Ms. Quijano said, "I don't know why these girls let (Resident A) hit them and pull their hair, I won't let her do that, I will hit her back, I won't let her hit me. I've hit her back and I know (Resident A) won't hit me again." Ms. Souza stated she told Ms. Quijano she cannot hit a resident under any circumstance and reported this incident to Ms. Bradley. Ms. Bradley stated on 01/18/2021, she called Ms. Quijano into her office and asked her about the incident where she told Ms. Souza she slapped Resident A's hands on two different occasions when Resident A was physically aggressive with staff. Ms. Bradley stated Ms. Quijano acknowledged that she knows she is not allowed to hit residents and told Ms. Bradley that she has not hit any residents. Ms. Bradley stated she asked Ms. Quijano what she would do if a resident hit her and Ms. Quijano responded by saying she would "back away and state, no, you cannot touch me, don't touch me." Ms. Souza stated she confronted Ms. Quijano, in Ms. Bradley's presence and stated, "so this weekend we spoke, and you expressed to me that you have hit (Resident A)" and Ms. Quijano responded by saying, "yes, when (Resident A) was hurting another staff member I have slapped her hands away." Ms. Bradley and Ms. Souza stated Ms. Quijano acknowledged to both of them that she knew she could not slap Resident A's hands and Ms. Bradley terminated Resident A's employment.

Resident A is in the memory care unit at the facility and is unable to participate in an interview due to dementia related cognitive limitations.

On 01/19/2021, I received and reviewed an Incident Report (IR) dated 01/18/2021 and written by Ms. Souza and signed by Ms. Bradley. The staff documented as being involved are Ms. Pimenta and Ms. Quijano. The IR documents the following information, '*staff (Ms. Quijano) explained to RCC (Resident Care Coordinator, Ms. Souza) she does not understand why other staff members allow resident to hit them, staff stated "she will not hit me, because I will hit her back." RCC states she cannot hit residents, staff then states, "I know (Resident A) won't hit me because I've hit her back." RCC asked you've hit resident? Staff states "yes, I've hit her back and she won't hit me anymore."* Cherry Quijano has been terminated. APS and State Licensing notified. Police report filed with Fruitport Township police.

On 01/19/2021, I interviewed Kylie Pimenta via telephone. Ms. Pimenta stated she worked at this facility from October 2020 until early December 2020 when she moved out of state. Ms. Pimenta stated the information in the complaint allegation is true and that she saw Ms. Quijano slap Resident A, this occurred sometime in October 2020 when she and Ms. Quijano were working together. Ms. Pimenta stated Resident A resided in the memory unit at this facility and she kept going into other resident rooms. Ms. Pimenta stated she was trying to redirect Resident A out of the other residents rooms when Resident A hit her (Ms. Pimenta). Ms. Pimenta stated Ms. Quijano came to help and Ms. Quijano slapped Resident A's hand to get her to stop slapping at Ms. Pimenta. Ms. Pimenta stated Resident A did not seem phased by this and "continued on about her business" as if nothing had happened. Ms. Pimenta stated this is the first and only time she has ever seen Ms. Quijano, or another other staff at this facility hit a resident. Ms. Pimenta stated she documented Resident A going into other resident rooms in the observation notes but did not document that Ms. Quijano slapped Resident A's hand. Ms. Pimenta stated she informed two supervisors, Ruth Baxter, and Charity Baxter at the time of the event.

On 01/19/2021, I called Ms. Quijano twice, there was no answer, the mailbox was full, and I was not able to leave a message.

On 01/20/2021, Ms. Bradley stated she reviewed the observation notes and on three separate occasions, October 15, 23 and 25, 2020, Ms. Pimenta and Ms. Quijano documented Resident A's agitation and physical aggressiveness with staff when they were trying to redirect her. Ms. Bradley stated she talked to Ms. Ruth Baxter and Ms. Charity Baxter, both of whom stated they were not notified in October 2020 of Ms. Quijano slapping Resident A's hands to get her to stop physical aggressiveness with staff.

On 01/22/2021, I received and reviewed Resident A's health care appraisal (HCA) dated 08/25/2020 and signed by Rhiannon Freiberg, PA-C (Physician's Assistant). The HCA documents Resident A as having '*vascular dementia with behavioral disturbance, anxiety and depression.*' I received and reviewed Resident A's

assessment plan for AFC residents dated 09/02/2020 and signed by Ms. Bradley and Resident A's designated representative Relative #1. The assessment plan documents Resident A's mood as *'Chronic anxiety or depression significantly interfering with daily functions, unmanaged with medications and needing frequent staff intervention.'* The assessment plan also documents Resident A's behavior as *'consistent behavior problems-difficult to redirect.'* There are no comments or instructions for staff to follow to deal with either Resident A's mood or behaviors.

On 01/25/2021, I received and reviewed the Fruitport Township Police report dated 1/18/2021 and written by Officer Jason Kuzyk. Officer Kuzyk documented the following, *'Dispatched to an assault report. Nicole Bradley stated that one of the residents was assaulted by an employee a few weeks ago. Nicole stated that (Resident A) was assaulted by Cherry Quijano. An employee Kylie Pimenta was said to have observed the incident. Nicole stated that (Resident A) grabbed Kylie. (Resident A) would not let go, so Cherry hit her hands so she would let go. Nicole stated that Cherry admitted to doing so. Cherry was fired due to the incident. Kylie quit and moved to Florida since the incident. I spoke with (Resident A). (Resident A) has dementia. (Resident A) did not recall the incident or the employee. Disposition: report turned over to Detective Rypstra.'*

On 01/25/2021, I interviewed Ruth and Charity Baxter independently via telephone. Ms. Ruth Baxter and Ms. Charity Baxter both stated they have no recollection of Ms. Pimenta reporting to them that Ms. Quijano slapped Resident A's hands in October 2020, nor have they ever seen or have any knowledge of Ms. Quijano slapping Resident A or any other resident in the facility.

On 01/28/2020, I conducted an Exit Conference with Program Director, Amber Fry as approved by Licensee Designee, Paul Wyman. Ms. Fry stated she will submit an acceptable corrective action plan.

<b>APPLICABLE RULE</b>	
<b>R 400.15305</b>	<b>Resident protection.</b>
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
<b>ANALYSIS:</b>	Based on investigative findings, there is a preponderance of evidence to show that in October 2020, staff Cherry Quijano slapped Resident A's hands when Resident A became physically aggressive with staff Kylie Pimenta.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**IV. RECOMMENDATION**

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



01/28/2021

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Elizabeth Elliott  
Licensing Consultant

Date

Approved By:



01/29/2021

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Jerry Hendrick  
Area Manager

Date