GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 10, 2025

Kimberly Wozniak
Wyoming Care Operations, LLC
1435 Coit Ave NE
Grand Rapids, MI 49505

RE: License #: AL410418568
Investigation #: 2025A0583032
Wyoming Woods #5

Dear Ms. Wozniak:

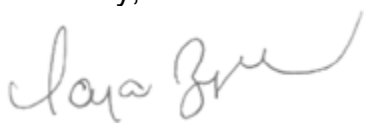
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0183.

Sincerely,



Toya Zylstra, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 333-9702

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL410418568
Investigation #:	2025A0583032
Complaint Receipt Date:	04/04/2025
Investigation Initiation Date:	04/08/2025
Report Due Date:	05/04/2025
Licensee Name:	Wyoming Care Operations, LLC
Licensee Address:	1435 Coit Ave NE Grand Rapids, MI 49505
Licensee Telephone #:	(616) 900-9717
Administrator:	Rebecca Jiggens
Licensee Designee:	Kimberly Wozniak, Designee
Name of Facility:	Wyoming Woods #5
Facility Address:	Suite 5 2600 WALDON WOODS DR SW WYOMING, MI 49519
Facility Telephone #:	(616) 900-9717
Original Issuance Date:	08/13/2024
License Status:	REGULAR
Effective Date:	02/13/2025
Expiration Date:	02/12/2027
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED, AGED, DEVELOPMENTALLY DISABLED, MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Staff failed to provide Resident A with adequate care.	No
Additional Findings	Yes

III. METHODOLOGY

04/04/2025	Special Investigation Intake 2025A0583032
04/04/2025	APS Referral
04/08/2025	Special Investigation Initiated - On Site
04/10/2025	Exit Conference Licensee Designee Kimberly Wozniak

ALLEGATION: Staff failed to provide Resident A with adequate care.

INVESTIGATION: On 04/04/2025 complaint allegations were received from Adult Protective Services Centralized Intake via the LARA-BCHS-Complaints system. The complaint was screened out for formal Adult Protective Services investigation. I observed that the complaint stated the following: *"(Resident A) (77) resides at an assisted living facility. (Resident A's) guardian is his daughter, (Relative 1). (Resident A) is diagnosed with dementia, obstructive renal failure, chronic urinary retention, and deconditioning. (Resident A) is able to ambulate independently. (Resident A) has at home health care through Trinity Health. (Resident A) has been pulling his foley out. Staff at Trinity Health removed the foley on 4/1/2025 after talking with (Relative 1). Today on 4/3/3035 (Resident A) had 4 liters of urine he urinated out. (Resident A) did not urinate for 2 days, there is concern that staff did not provide (Relative 1) with the proper education on pulling a foley out, and there is concern as staff did not notice that (Resident A) did not urinate for 2 days".*

On 04/08/2025 I completed an unannounced onsite investigation at the facility and interviewed administrator Rebecca Jiggens, staff Xochitl Vargas, and Resident A.

Administrator Rebecca Jiggens stated that Resident A is diagnosed with dementia, aphasia, and his legal decision maker is Relative 1. Ms. Jiggens stated that Resident A is ambulatory and takes daily walks. Ms. Jiggens stated that Resident A has a history of urine retention. Ms. Jiggens stated that Resident A had a Foley catheter placed in the past however Resident A frequently pulled the catheter out. Ms. Jiggens stated that on 04/01/2025, Resident A's in-home nurse from Trinity Home Care removed Resident A's catheter at the request of Resident A's daughter, Relative 1. Ms. Jiggens stated that Resident A's Assessment Plan was not updated to reflect the removal of Resident A's catheter on 04/01/2025 which required facility

staff to check Resident A's adult brief “every two hours”. Ms. Jiggens explained that Resident A often toileted himself due to his independent ambulation however staff were required to check Resident A’s adult briefs and change them as necessary. Ms. Jiggens stated that on 04/03/2025 Resident A’s in-home nurse returned to the facility for a regularly scheduled visit to observe Resident A’s baseline following the catheter removal. Ms. Jiggens stated that it was observed that Resident A exhibited a fever and was withholding urine. Ms. Jiggens stated that the in-home nurse placed Resident A’s catheter back in and 3,000cc of urine was extracted. Ms. Jiggens stated that Resident A was immediately sent to the emergency department and was diagnosed with a urinary tract infection. Ms. Jiggens stated that facility staff did not observe that Resident A was withholding his urine from 04/01/2025 until 04/03/2025 because Resident A often toileted himself independently. Ms. Jiggens stated that staff also were not aware Resident A had a fever until 04/03/2025. Ms. Jiggens stated that from 04/01/2025 until 04/03/2025, Resident A did not display behaviors outside his normal baseline and staff were checking Resident A’s adult brief often. Ms. Jiggens stated that Resident A returned to the facility on 04/03/2025 with his catheter in place and he has not pulled out the catheter again. Ms. Jiggens stated that Resident A’s Assessment Plan has not been updated to reflect the insertion of Resident A’s catheter.

Staff Xochitl Vargas stated that on 04/01/2025 Resident A’s catheter was removed at the direction of Relative 1 due to Resident A pulling the catheter out often. Ms. Vargas stated that from 04/01/2025 until 04/03/2025 facility staff checked Resident A’s adult brief every two hours. Ms. Vargas stated that Resident A often independently toilets himself in addition to staff check and changes therefore Resident A’s urine retention was unnoticed. Ms. Vargas stated that on 04/03/2025, Resident A was sent to the emergency department due to continued urine retention and a fever. Ms. Vargas stated that Resident A was diagnosed with a urinary tract infection. Ms. Vargas stated that Resident A arrived back to the facility on 04/03/2025 with his catheter in place. Ms. Vargas stated that Resident A continues to utilize the catheter and has not pulled it out since then.

Resident A was observed outside of the facility while walking down the sidewalk in front of the facility. Resident A was utilizing a walker for ambulation assistance. Resident A was able to speak, but due to his cognitive decline Resident A was unable to provide answers to questions. He was appropriate dressed and groomed.

While onsite I observed Resident A’s Assessment for AFC Residents, signed 10/18/2024. The documentation states that Resident A can move independently within the community, can communicate his needs, and understands verbal communication. In addition, the documentation states that Resident A does not require assistance with toileting and bathing.

While onsite I observed a document titled, “Optilis Health and Rehab Grand Rapids Order Summary.” completed on 10/17/2024. The document states that Resident A is

diagnosed with retention of urine, unspecified dementia moderate without behavioral disturbances, and aphasia.

While onsite I observed a document titled “Wyoming Woods Progress Note” with effective dates of 04/04/2025 until 04/09/2025. The documentation stated that on 04/04/2025 “Rt arrived with daughter from hospital, and he have a new catheter in place”. The documentation stated that on 04/03/2025, “RT’s nurse came back this afternoon to see how he was doing without his catheter” and “when she put in a new one 3000cc of urine came out”. The documentation further stated that Resident A “went to St. Mary’s” and displayed a “fever of 101”. The documentation stated that on 04/01/2025 “nurse came and remove Rt’s catheter” and “his tasks were updated to every 2 hours checks”.

On 04/10/2025 I completed an Exit Conference via telephone with licensee designee Kimberly Wozniak. Ms. Wozniak stated that she agreed with the findings.

APPLICABLE RULE	
R 400.15303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Administrator Rebecca Jiggens stated that on 04/01/2025, Resident A’s in-home nurse from Trinity Home Care removed Resident A’s catheter at the request of Relative 1. Ms. Jiggens stated that Resident A’s Assessment Plan was not updated to reflect the removal of Resident A’s catheter which required facility staff to check Resident A's adult brief “every two hours”. Ms. Jiggens explained that Resident A often toileted himself due to his independent ambulation however staff were required to check Resident A’s briefs and change them as necessary. Ms. Jiggens stated that on 04/03/2025 Resident A’s in-home nurse returned to the facility for a regularly scheduled visit to observe Resident A’s baseline following the catheter removal. Ms. Jiggens stated that it was discovered that Resident A had a fever and was withholding urine. Ms. Jiggens stated that the in-home nurse placed Resident A’s catheter back in place and 3000cc of urine was extracted. Ms. Jiggens stated that Resident A was immediately sent to the emergency department and was diagnosed with a urinary tract infection. Ms. Jiggens stated that facility staff did not observe that Resident A was withholding his urine from 04/01/2025 until 04/03/2025 because Resident A often toileted himself independently.

	Staff Xochitl Vargas stated that on 04/01/2025 Resident A's catheter was removed as the direction of Relative 1 due to Resident A pulling said catheter out often. Ms. Vargas stated that from 04/01/2025 until 04/03/2025 facility staff checked Resident A's adult brief every two hours. Ms. Vargas stated that Resident A often independently toilets himself in addition to staff check and changes therefore Resident A's urine retention was unnoticed. Ms. Vargas stated that on 04/03/2025, Resident A was sent to the emergency department due continued urine retention and a fever. Resident A's Assessment for AFC Residents states that Resident A can move independently within the community, can communicate his needs, and understands verbal communication. The documentation states that Resident A does not require assistance with toileting and bathing. A document titled, "Optilis Health and Rehab Grand Rapids Order Summary" states that Resident A is diagnosed with retention of urine, unspecified dementia moderate without behavioral disturbances, and aphasia. A preponderance of evidence was not discovered to substantiate violation of the applicable rule. Resident A is ambulatory and often toilets himself therefore it was not observed by facility staff that Resident A had retained a large volume of urine from 04/01/2025 until 04/03/2025.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS: Staff failed to update Resident A's current care needs into his Resident Care Agreement.

INVESTIGATION: On 04/08/2025 I completed an unannounced onsite investigation at the facility and interviewed administrator Rebecca Jiggens.

Administrator Rebecca Jiggens stated that Resident A had a Foley catheter placed in the past however Resident A would often pull the catheter out. Ms. Jiggens stated that on 04/01/2025, Resident A's in-home nurse from Trinity Home Care removed Resident A's catheter at the request of Resident A's daughter, Relative 1. Ms. Jiggens stated that Resident A's Assessment Plan was not updated to reflect the removal of Resident A's catheter on 04/01/2025 which required facility staff to check Resident A's adult brief "every two hours". Ms. Jiggens explained that Resident A often toileted himself due to his independent ambulation however staff were required to check Resident A's adult briefs and change them as necessary. Ms. Jiggens

stated that on 04/03/2025 Resident A's in-home nurse returned to the facility for a regularly scheduled visit to observe Resident A's baseline following the catheter removal. Ms. Jiggens stated that Resident A exhibited a fever and was withholding urine. Ms. Jiggens stated that the in-home nurse placed Resident A's catheter back in place and 3000cc of urine was extracted. Ms. Jiggens stated that Resident A was immediately sent to the emergency department and was diagnosed with a urinary tract infection. Ms. Jiggens stated that facility staff were not aware that Resident A was withholding his urine from 04/01/2025 until 04/03/2025 because Resident A often toileted himself independently. Ms. Jiggens stated that staff were also not aware that Resident A had a fever until 04/03/2025. Ms. Jiggens stated that from 04/01/2025 until 04/03/2025, Resident A did not display behaviors outside of his normal baseline and staff were checking Resident A's adult brief often. Ms. Jiggens stated that Resident A returned back to the facility on 04/03/2025 with his catheter in place and Resident A has not pulled it out again. Ms. Jiggens stated that Resident A's Assessment Plan has not been updated to reflect the insertion of Resident A's catheter.

While onsite I observed Resident A's Assessment for AFC Residents, signed 10/18/2024. The documentation states that Resident A can move independently within the community, can communicate his needs, and understands verbal communication. The documentation states that Resident A does not require assistance with toileting and bathing. The documentation does not reflect the removal of Resident A's Foley Catheter from 04/01/2025 until 04/03/2025 which resulted in the need for staff assisting with toileting and adult brief changes every two hours and the documentation was not updated the removal of Resident A's Foley Catheter on 04/03/2025. The current Assessment Plan was reviewed and does not indicate that Resident A's diagnosis of dementia and aphasia.

On 04/10/2025 I completed an Exit Conference via telephone with licensee designee Kimberly Wozniak. Ms. Wozniak stated that she did not dispute the findings of the investigation and would submit an acceptable Corrective Action Plan.

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.

ANALYSIS:	Resident A's Assessment for AFC Residents, signed 10/18/2024 states that Resident A can move independently within the community, can communicate his needs, and understands verbal communication. The document states that Resident A does not require assistance with toileting and bathing. The documentation also does not reflect the removal of Resident A's Foley Catheter from 04/01/2025 until 04/03/2025 which resulted in the need for staff assistance with toileting and adult brief changes every two hours and the documentation was not updated after the removal of Resident A's Foley Catheter on 04/03/2025. The current Assessment Plan does not include Resident A's diagnosis of dementia, aphasia, and urinary retention. A preponderance of evidence was discovered to substantiate a violation of the applicable rule. A current review of the Assessment Plan indicates that the plan does not reflect the needs of the resident. Resident A has been diagnosed with dementia, aphasia, and urinary retention. The current plan lacks a plan to adequately address these areas.
CONCLUSION:	**VIOLATION ESTABLISHED**

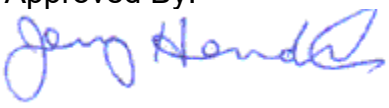
IV. RECOMMENDATION

Upon receipt of an acceptable Corrective Action Plan, I recommend no change to the license.

04/10/2025

Toya Zylstra Date
Licensing Consultant

Approved By:



04/10/2025

Jerry Hendrick Date
Area Manager