



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 9, 2025

Teresa Wendt
HGA Non-Profit Homes Inc.
917 West Norton
Muskegon, MI 49441

RE: License #:	AS610411453
Investigation #:	2026A0356007
	Black Creek Cove

Dear Ms. Wendt:

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,

A handwritten signature in black ink that reads "Elizabeth Elliott". The signature is written in a cursive style with a large, looping initial "E".

Elizabeth Elliott, Licensing Consultant
Bureau of Community and Health Systems
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 #:	AS610411453
Investigation #:	2026A0356007
Complaint Receipt Date:	10/31/2025
Investigation Initiation Date:	10/31/2025
Report Due Date:	12/30/2025
LicenseeName:	HGA Non-Profit Homes Inc.
Licensee Address:	917 West Norton Muskegon, MI 49441
Licensee Telephone #:	(231) 728-3501
Administrator:	Teresa Wendt
Licensee Designee:	Teresa Wendt
Name of Facility:	Black Creek Cove
Facility Address:	2315 E. Broadway Ave. Muskegon, MI 49444
Facility Telephone #:	(616) 842-4949
Original Issuance Date:	03/11/2022
License Status:	REGULAR
Effective Date:	09/11/2024
Expiration Date:	09/10/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL, AGED

II. ALLEGATION(S)

	Violation Established?
Resident A sustained an injury in the facility and medical treatment was not sought immediately.	Yes

III. METHODOLOGY

10/31/2025	Special Investigation Intake 2026A0356007
10/31/2025	APS Referral Ken Beckman, APS, Muskegon County.
10/31/2025	Special Investigation Initiated - Telephone Ken Beckman.
10/31/2025	Contact - Document Received Ken Beckman, picture of injury.
10/31/2025	Contact - Document Sent Teresa Wendt, Licensee Designee.
10/31/2025	Contact - Document Received Ken Beckman sent Trinity Health notes.
11/03/2025	Inspection Completed On-site
11/03/2025	Contact - Face to Face Teresa Wendt, Ken Beckman, APS, Linda Wagner, ORR, James Coleman, DCW, Antonio Day, DCW, Melissa Skuse, home manager.
11/03/2025	Contact - Face to Face Jonathan Jackson, DCW, Resident A.
11/04/2025	Contact - Document Received Linda Wagner, ORR's notes on interview with DCW Jennifer Piggue.
11/05/2025	Contact - Document Received Linda Wagner, consultation with Suzanne Beckman, HW CMH nurse.
11/06/2025	Contact - Telephone call made

	Sheena Kimball, DCW.
11/09/2025	Exit conference-Teresa Wendt, Licensee Designee.

ALLEGATION: Resident A sustained an injury in the facility and medical treatment was not sought immediately.

INVESTIGATION: On 10/31/2025, I received a LARA-BCHS (Licensing and Regulatory Affairs, Bureau of Community Health Systems) online complaint. The complainant reported that Resident A was brought to Urgent Care on 10/29/2025 by staff (name unknown) from the AFC facility. The complainant reported that Resident A had a burn on her leg which staff thought looked like it needed medical attention and the explanation staff gave about the cause of the injury was that Resident A had spilled hot oatmeal on her leg on either Sunday, 10/26/2025 or Monday, 10/27/2025. However, the staff expressed concern that the cause of the injury did not seem plausible based on the shape of the injury.

The complainant explained that Resident A had a rectangular shaped burn on her upper left thigh that was 2.5X7cm with well-defined borders. It was diagnosed as a partial thickness, 2nd degree burn. There had been a blister which had already come off. The wound was very red and there were concerns for infection. Resident A was prescribed an oral and topical antibiotic. Resident A is non-verbal and could not give any details about what happened. The staff had concerns that protocol was not followed by not bringing Resident A to see a doctor after the injury.

On 10/31/2025, I interviewed Ken Beckman, Muskegon County Department of Health and Human Services (DHHS), Adult Protective Services Worker (APS) via telephone. Mr. Beckman stated he went to the facility and saw Resident A. She is non-verbal and not able to provide pertinent information in this investigation. Mr. Beckman stated Resident A appeared well cared for and seemed happy.

On 10/31/2025, I reviewed Trinity Health notes dated 10/29/2025, 9:00a.m., by B. Cartmill, PA (physician's assistant), diagnosed '*partial thickness burn of left thigh. Initial encounter.*' Resident A was prescribed Doxycycline and Mupirocin with instructions as follows: '*Good layer of antibiotic ointment. Apply antibiotic ointment 3 times daily. Give oral antibiotic as directed until gone for suspected secondary infection from burn. Make close follow-up appointment with her primary care provider within the next 3 to 5 days for recheck and to discuss mechanism of injury. Go to emergency department sooner if she develops fever, worsening redness surrounding wound, worsening pain.*'

On 10/31/2025, I reviewed a photo sent from Mr. Beckman of Resident A's burn. I observed a burn located on Resident A's upper left thigh and it appeared rectangular in shape. The burn is red, and it appears as though there had been a blister, but the

blister is no longer covering the wound. I observed a long red mark above the burn and what could be a small burn further up the thigh.

On 11/03/2025, I interviewed DCW's (direct care workers) at HGA's main office with Ken Beckman, DHHS, APS worker, Linda Wagner, Health West, Office of Recipient Rights and Teresa Wendt, Licensee Designee. Ms. Wendt stated from what she has learned, Resident A's injury occurred on or about Sunday, 10/26/2025. Resident A was taken to Urgent Care for evaluation and treatment on Wednesday, 10/29/2025.

Ms. Wagner, Mr. Beckman and I interviewed DCW, James Coleman at the HGA office. Mr. Coleman stated on Sunday, 10/26/2025, he worked with DCW Antonio Day at this facility. They recently began working at this facility and typically worked at another HGA home which is being renovated. Mr. Coleman stated he was the medication lead that day and was busy preparing resident medications in the medication room while Mr. Day prepared breakfast which was oatmeal. Mr. Coleman stated Mr. Day was still cooking in the kitchen when he went to the dining room to administer a resident's medication. He noticed that Resident A had wet pants from oatmeal that she had spilled down the front of her. Mr. Coleman stated he told Mr. Day that Resident A had "wasted" her oatmeal down the front of her so Mr. Day left the kitchen and cleaned Resident A's pants of the oatmeal. Mr. Coleman stated when he was finished administering resident medications, he changed Resident A's brief and noticed a red mark on her upper left thigh. Mr. Coleman stated the mark was red. It was not a blister nor was it bubbled up or an open sore. It appeared as a red mark on her skin. Mr. Coleman stated he could not find any ointment for her skin, so he took a 4x4 piece of gauze, folded it in half and covered the red mark with the gauze. Mr. Coleman stated he could tell the mark was red and "irritated" but had no idea it was a burn. Mr. Coleman stated Resident A had thin leggings on and the red mark could have been from spilling her oatmeal down the front of her and onto her lap. Mr. Coleman stated Resident A never screamed or made any type of sound to notify staff that she was in any type of distress or pain, and he has no idea, other than Resident A spilling oatmeal, how she could have sustained a burn.

Mr. Coleman stated he worked on Sunday, 10/26/2025, he did not work on Monday, 10/27/2025 and was back at work on Tuesday, 10/28/2025. Mr. Coleman reported while he was not at work (on Monday, 10/27/2025) there was another DCW at the facility that noticed Resident A's injury and inquired about it to the supervisor, Ms. Skuse. Mr. Coleman stated on Wednesday, 10/29/2025, another DCW took Resident A to Urgent Care. Mr. Coleman stated he wrote an IR (incident report) on Sunday 10/26/2025 and left it on Melissa Skuse's desk, home manager. Mr. Coleman stated when he returned to work, he did not see the IR on Ms. Skuse's desk and assumed she took care of it. Mr. Coleman stated he did not verbally report Resident A's injury because when he noticed it on Sunday, 10/26/2025, it was a red mark on Resident A's thigh, he did not think Resident A needed immediate medical attention, and he assumed Ms. Skuse would see the IR and "do with it what she needed to do."

On 11/03/2025, I interviewed DCW Antonio Day with Mr. Beckman, Ms. Wagner and Ms. Wendt. Mr. Day stated he is new to working at this home and usually worked at another HGA home that is being renovated. Mr. Day stated he worked on Sunday, 10/26/2025. He was making breakfast of oatmeal for the residents and Resident A was up, ready for breakfast, and sitting at the dining room table. Mr. Day stated he gave Resident A oatmeal and was preparing other residents' breakfasts when Mr. Coleman walked by and said Resident A's oatmeal spilled, and that he would pass the last medication he had and would clean Resident A up. Mr. Day stated Mr. Coleman changed Resident A's brief and pants and stated it appeared as though her skin was irritated on the upper thigh. Mr. Day stated Resident A had a wrap around her torso that closed with Velcro to keep her ostomy bag in place, and he removed that because most of the spilled oatmeal landed down the front of her, then Mr. Coleman changed Resident A's pants. Mr. Day stated he did not see Resident A spill her oatmeal on herself and he never saw the red mark on Resident A's thigh. Mr. Day stated the oatmeal he served to Resident A was not so hot that it would burn through clothing. Mr. Day reported that Resident A never screamed, yelled or gave any indication that she was in pain or hurt during this shift, so Mr. Day has no idea other than the spilled oatmeal as to how Resident A sustained a burn. Mr. Day stated Mr. Coleman wrote an IR.

On 11/03/2025, I interviewed Melissa Skuse, stand-in home manager, with Mr. Beckman, Ms. Wagner and Ms. Wendt. Ms. Skuse stated on Sunday, 10/26/2025 she got a message from Mr. Coleman asking about a 1st aid kit, but he did not tell her that anything had happened or that Resident A had an injury. Ms. Skuse stated on Sunday, 10/26/2025, 2nd shift DCW Jennifer Piggue asked her (Ms. Skuse) if she "saw this burn". Ms. Piggue reported that she put cream on the wound, but Ms. Skuse had not yet seen the wound. Ms. Skuse stated on Monday, 10/27/2025, she worked on the floor and DCW Jonathan Jackson took care of Resident A in the bathroom. Ms. Skuse stated Mr. Jackson said, "come look at this," so Ms. Skuse observed the wound on Resident A's leg and Mr. Jackson stated he did not think it looked like a burn from oatmeal and neither did she (Ms. Skuse). Ms. Skuse stated she had asked staff, Ms. Piggue, Jonathan Jackson, and Renetta Levelston on Monday, 10/27/2025 and Tuesday, 10/26/2025 to take Resident A to Urgent Care but no one could take her because they were not "van trained". On Tuesday, 10/28/2025, Ms. Skuse stated she was working on the floor at another HGA facility and called DCW Sheena Kimball and asked if she could take Resident A to the Urgent Care Center. Ms. Skuse stated Ms. Kimball took Resident A to Urgent Care on Wednesday, 10/29/2025.

On 11/03/2025, I conducted an unannounced inspection at the facility and interviewed DCW Jonathan Jackson. Mr. Jackson stated he worked on Monday, 10/27/2025 and Tuesday, 10/28/2025 and saw Resident A's burn injury. Mr. Jackson stated on Monday, the burn "didn't look bad," it looked like a little burn with a square shape to it but not that bad. Mr. Jackson stated he put ointment on the wound and covered it with gauze. Mr. Jackson stated on Tuesday, the burn was "puffy" and

“didn’t look ok,” so, he (Mr. Jackson) patched the wound up again by putting ointment on it and gauze over the top.

It is noted that the residents in this facility, including Resident A cannot provide pertinent information to this investigation due to cognitive deficiencies.

On 11/04/2025, Ms. Wagner interviewed Jennifer “Jen” Piggue, DCW via telephone. Ms. Piggue reported the following information to Ms. Wagner, *‘On Sunday, 10-26-2025, I got to work, James (Mr. Coleman) was working with me until 7 that day. When I got there, he (Mr. Coleman) was in the Med Room. (Resident A) was sitting in her chair. Around 4:45-5, I got up to toilet (Resident A) and when I pulled down her pants and her brief, I noticed that she had a bad burn on her thigh. I got it cleaned up, and put a gauze on it, and I came out, and I asked James (Mr. Coleman), what happened?’*

He told me that (Resident A) was sitting at the table and oatmeal fell on her thigh, instantly felt like that was a setup. I know how (Resident A) is placed under the table and my attitude was, if a bowl of oatmeal fell it would have fell between her chest and her stomach because she's pushed in at the table to wear her thighs isn't exposed.

Jen (Ms. Piggue) said, have you notified Melissa (Ms. Skuse)? And he told me no. He said he did an IR and put it on a desk. Jen said she said to James, you can take her to the ER, because you are the med lead, you have control to do that. And you had another worker here, you could have taken her to the ER, he said, no, because he said I don't feel like it's that serious.

So, I texted Melissa and said, (Resident A) has a bad burn on her thigh and there is no burn treatment here. She asked how did she get burned, I said, he (Mr. Coleman) said oatmeal, I told her it was really bad.

She said, “Can you take her to the Medi Center? Did he write an IR? I said yeah, he wrote it. Then I told her I couldn't take her to the med center because I wasn't van trained. And that's how that situation started.

Ms. Piggue reported he (Mr. Coleman) didn't notify anyone, and as far as the issue happening it was on his watch, he did nothing. Ms. Wagner stated she asked Ms. Piggue, what did the burn look like when you first saw it on Sunday and Ms. Piggue stated, the skin was peeling around it, it was white skin but in red specks to where you can tell that it was irritated. It was fresh and then she had another little spot on her stomach that was red as well. To me (Jen) it looks like something hot hit where the burn was on her stomach, you can tell that it's the same shape. It could have been burned too but it didn't go through skin. Ms. Piggue took a picture of the burn.

Ms. Piggue stated Monday came around, and Melissa (Skuse) had us cleaning it and putting burn cream and changing out the gauze. I was telling Melissa that I

think she needs to go in and be seen. Melissa said she was going to have the third shift that came in at 7 to take her to ER, but I'm like that's not going to work, she will be here by herself. And so that's when she came up with having someone come in the next morning and take her to the emergency room. Jen said she should have went in on Sunday to have it looked at.

By this time it was infected, and they (the Medi center people) felt like it wasn't a oatmeal burn and it look like a grease spill or something, but I don't think it looked like grease either. We don't know what actually happened because they're not really saying what happened.

I've been here since March and it's hard to tell when she's uncomfortable, Resident A is so friendly, she wants to be around people but, I see how she responded to James (Mr. Coleman) the day it happened. He (Mr. Coleman) tried to get (Resident A) to let him assist her in the bathroom and (Resident A) wouldn't get up to go to the bathroom for him. But when another staff member asked her to go to the bathroom she got up just fine. Jen said she could tell that something was wrong with her, and he (Mr. Coleman) was the issue because she would no longer interact with him.

These guys need to know that you got to watch her (Resident A), she is going to go to the kitchen, and you have to stay up, to prevent her from going in the kitchen, so she won't get into things. But if you are not watching, (Resident A) is going to get into something.'

11/05/2025, Ms. Wagner consulted with Health West RN (registered nurse), Suzanne Beckman at Health West clinic. Ms. Beckman gave Ms. Wagner the following information, *'In her medical opinion that the burn/wound was not caused by oatmeal. When she first looked at the photo, she said that she did not think it was a burn that it could be an abrasion.*

Suzanne then reviewed the notes from Bryn Cartmill, PA with Trinity Health (IHA Medical Group) which referred to the injury as a burn that appears to be a thermal or heat-induced injury with well demarcated borders. This report also states that if it had been caused by oatmeal that the borders would have been irregular. Suzanne said that based on the urgent care's records they are calling it a second-degree burn.

Suzanne said this would not be caused by a Colostomy/Ostomy bag based on that report. It was caused by something that shape (the shape of the wound) that she either leaned against or laid on. She said we may never know.

Suzanne said in her medical opinion the delay in getting treatment contributed to the site becoming infected, but it is hard to say if the bag had any part of the issue or contributed to the increased irritation.'

On 11/06/2025, I interviewed DCW Sheena Kimball, via telephone. Ms. Kimball stated she works 1st and 2nd shifts at the facility but mainly 1st shift. Ms. Kimball stated she took Resident A to Urgent Care on Wednesday, 10/29/2025. This day was her first day back to work after 5 days off, so she does not know what had happened to cause this injury. Ms. Kimball stated Mr. Coleman stated Resident A had sustained a burn from oatmeal so when she went to Urgent Care, she told staff at Urgent Care she had been told the burn on Resident A came from oatmeal. Ms. Kimball stated staff at Urgent Care said the burn did not look like a burn from oatmeal. Ms. Kimball stated Resident A sits up tight to the table when she eats. Her legs are under the table and if she “wasted” food, which she does not spill food, it would never hit her leg or upper thigh where the burn was. Ms. Kimball added that Resident A does not touch the stove or oven top and if she did, her fingers would have burns and they do not. Ms. Kimball stated the burn appears to be in the shape of a spatula or a baking pan. Ms. Kimball stated Ms. Piggue works 2nd shift. She took the picture of the burn, and she (Ms. Piggue) would have been the next worker on shift after Mr. Coleman and Mr. Day’s shift. Ms. Kimball stated Resident A’s burn was infected according to staff at Urgent Care. She was prescribed ointment for the skin and an antibiotic. Ms. Kimball stated Resident A will cry or make a noise and would have yelled when this injury happened. Ms. Kimball stated something happened and Mr. Coleman and Mr. Day never called anyone about it.

On 11/06/2025, I reviewed the IR dated 10/26/2025, 9:30a.m., written by James Coleman on 10/26/2025 at 10:18 a.m. and signed by Melissa Skuse on 10/28/2025. The IR documented the following information: *‘After (Resident A) finished breakfast, I seen that she spilled most of her oatmeal in her lap, really her outer left thigh. I helped get the oatmeal off her pants but had to finish med pass before I could change her pants. When I changed her pants, I seen that her skin started to peel and was red like it was raw so I covered it with a 4X4 gauze folded in half, the redness was 4 inches long because the bandage covered it completely.’* Ms. Skuse added to the IR, *‘I was notified late, spoke to staff about contacting myself and a nurse for injuries, first aid was done correctly, but did not seek medical care.’*

On 12/09/2025, I conducted an exit conference with Teresa Wendt, Licensee Designee. Ms. Wendt stated she understood the information presented in the report, and she agreed with the analysis and conclusion of these applicable rules. Ms. Wendt stated she will submit an acceptable corrective action plan which will include disciplinary actions taken and retraining of staff.

APPLICABLE RULE	
R 400.681	Resident rights; licensee responsibilities.
	(1) A resident shall be treated with dignity and respect, free from exploitation, protected and safe.

ANALYSIS:	<p>The complainant reported Resident A sustained a burn on her leg and staff reported Resident A had spilled hot oatmeal on her leg.</p> <p>Based on investigative findings, Resident A sustained a 2nd degree burn on her upper left thigh and the DCW's cannot definitively explain how Resident A got the burn. Staff at the facility failed to provide protection and safety to Resident A and therefore, a violation of this applicable rule is established.</p>
CONCLUSION:	VIOLATION ESTABLISHED

APPLICABLE RULE	
R 400.689	Resident health care.
	(3) In case of an accident or sudden adverse change in a resident's health condition, a facility shall obtain needed health care immediately.
ANALYSIS:	<p>The complainant reported that Resident A was brought to Urgent Care on 10/29/2025 and Resident A's injury occurred on either Sunday, 10/26/2025 or Monday, 10/27/2025.</p> <p>Resident A sustained a 2nd degree burn to her upper thigh on or about Sunday, October 26, 2025. Resident A was not seen by medical professionals until Wednesday, October 29, 2025, which is a delay of at least three days between Resident A's injury and medical care being sought. Therefore, a violation of this applicable rule is established.</p>
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

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

Elizabeth Elliott

12/09/2025

Elizabeth Elliott
Licensing Consultant

Date

Approved By:



12/09/2025

Jerry Hendrick
Area Manager

Date