GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 23, 2025

Kimberly Wozniak
Valley Pines Senior Living
6117 Charlevoix Woods Ct.
Grand Rapids, MI 49546-8505

RE: License #: AH410410352
Investigation #: 2026A1021009
Valley Pines Senior Living

Dear Kimberly 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 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 #:	AH410410352
Investigation #:	2026A1021009
Complaint Receipt Date:	11/25/2025
Investigation Initiation Date:	11/26/2025
Report Due Date:	1/25/2025
LicenseeName:	Cascade Care Operations LLC
Licensee Address:	144 940 Monroe Ave NW Grand Rapids, MI 49503
Licensee Telephone #:	(616) 308-6915
Administrator:	DaleTron Thompson
Authorized Representative:	Kimberly Wozniak
Name of Facility:	Valley Pines Senior Living
Facility Address:	6117 Charlevoix Woods Ct. Grand Rapids, MI 49546-8505
Facility Telephone #:	(616) 954-2366
Original Issuance Date:	05/24/2022
License Status:	REGULAR
Effective Date:	08/01/2025
Expiration Date:	07/31/2026
Capacity:	71
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Resident A's wounds were not cared for.	Yes
Additional Findings	No

III. METHODOLOGY

11/25/2025	Special Investigation Intake 2026A1021009
11/26/2025	Special Investigation Initiated - Telephone left message with facility
11/26/2025	Contact - Telephone call made interviewed administrator
12/02/2025	Contact - Document Received received Resident A's documents
12/02/2025	Contact - Telephone call made interviewed Hospice
12/0/5/2025	Contact - Document Received received hospice documentation
12/08/2025	Contact-Telephone call made Interviewed Hospice Nurse
12/23/2025	Exit Conference

ALLEGATION:

Resident A's wounds were not cared for.

INVESTIGATION:

On 11/25/2025, the licensing department received a complaint with allegations on 08/29/2025, Resident A was transferred to the hospital and Resident A was found to have a black spot on his foot, was prescribed antibiotics, and was to follow up with a podiatrist. The complainant alleged Resident A was transferred back to the facility and the facility was to monitor Resident A's feet. The complainant alleged Resident

A’s wounds worsen due to not being checked on and on 10/27/2025, Resident A was sent back to the hospital and was diagnosed with MRSA.

On 11/26/2025, I interviewed facility administrator DaleTron Thompson by telephone. The administrator reported Resident A was a resident that was being followed by Interim Health for skilled nursing and Home MD was also providing care to Resident A. The administrator reported on 10/27/2025, Resident A appeared more confused, and the facility was concerned about an infection, so Resident A was transferred to the hospital for an evaluation.

On 12/02/2025, I interviewed Interim Health coordinator Mandy Unger by telephone. The coordinator reported that Interim Health was providing wound care three times a week and Resident A was also being followed by Home MD for wound care. The coordinator reported Interim nurses reported multiple times that Resident A was observed not to have wound dressings on his feet.

On 10/08/2025, I interviewed Interim Home Care Nurse by telephone. The nurse reported that at times Resident A was observed to have soiled dressings or no dressings at all. The nurse reported that it was not certain how long Resident A was without the dressings on his wounds. The nurse reported that only once was the company contacted for a PRN visit and this was because the wound had popped. The nurse reported that there is a home care communication form that is completed after each visit, but communication with facility was hard as it was difficult to find management.

I reviewed Interim Health home care documentation. The documentation read, *“9/6 Orders: Patient is a 61-year-old male. Patient's focus of care is right foot wound. The patient uses a wheelchair for ambulation and is currently non-weight-bearing on the right foot. The patient has a wound in the right plantar foot that started out as a blister, requiring wound care. The patient also has a skin lesion on the left plantar foot. The patient has no sensation in his lower extremities and is not experiencing any pain. Provided instructions on avoiding walking on the right foot and to pivot on the toes if necessary. Patient's goal is wound to heal and return to full weight bearing status.*

9/12: (Dressing) soiled upon (skilled nursing visit), pt not remaining NWB. appears that patient has removed skin, enlarging wound area of foot. (Dressing) soiled upon (skilled nursing visit) pt not remaining NWB. Patient states ALF not providing much assist, states could use more for safety, ADLs, shower asst. Facility cg unavailable this visit. written comm for ALF for SNV, noting next visit and care completed this visit; requested ALF staff to assist pt /w ADLs and to remind pt to keep bandages clean. pt assessed, educated, and evaluated on skilled interventions as noted

9/15: feet soiled, indicating walking around barefoot. Drsg absent upon snv. ALF staff unavailable to provide BG reading pt lying in bed, feet elevated feet soiled, indicating walking around barefoot. Drsg not present upon snv. Reminded pt not to

remove drsg. lateral aspect of Rt plantar foot deteriorating. patient noted to have been picking/pulling at dry skin bil feet. guardian to be contacted prn and upon status chg per phone contact with guardian, Missy. written doc provided to ALF re: SN visit: encourage patient to wear shoes at all times when out of bed. HomeMD wound care to visit 9/17. pt assessed, educated, and evaluated on skilled interventions as noted. cg unavailable this visit ALF notified of visit and next visit via written communication.

9/17: RLE plantar wound surround appears to be "picked at" by pt, areas of calloused skin have been removed. NP contacted cg unavailable this visit. pt and cg assessed, educated, and evaluated on skilled interventions as noted. ALF provided written doc of SNV.

9/22: pt concerned about wounds, validated pt concerns and provided education to reduce anxiety. Pt baseline noted to be anxious about care and follow up about care. SN schedule placed on pt calendar to help alleviate anxiety of when care will be provided. Conversation with Tom Finn, NP re: POC, progress towards goals, wound care and frequency, guardianship. cg not available this visit. ALF notified via written doc of SN visit. pt assessed, educated, and evaluated on skilled interventions as noted. Facility contact and needs for more care, reminders for care, ability to perform drsg change?

9/24: pt states increased (blood pressure) due to anxiety and lack of sleep from incidents leading to roommate going to hospital. no s/s HTN education provided about using wheelchair at all times to reduce pressure on wounds; encouraged pt to use wc at all times. updates provided to Tom Finn wound NP for Lt foot lesion and spread of blister facility cg unavailable this visit, Written documentation provided to ALF re: SN visit this date with updates: wound changes, Htn, and expressed anxiety r/t wounds 2/t staff telling him that he would end up in hospital like his roommate. Reminded staff that PT is NWB. Guardian contact, VM left for return call.

9/26: reminder and education provided about not walking to relieve pressure on healing wounds. provided SN visit timeframe for pt on calendar to help reduce anxiety episodes, also included Tom, NP, visits. pt and cg assessed, educated, and evaluated on skilled interventions as noted. cg not present this visit. written comm to ALF re: sn visit.

9/27: PRN visit requested by pt to perform wound care to left foot. Pt up in W/C upon arrival and agreeable to visit. He was thankful that this nurse arrived. Transferred to bed so that wound care could be performed. Upon removal of old dressing noted that left bottom of foot blister had popped. Surrounding skin was intact. No S/S infection. Cleansed area and redressed for protection. Pt struggling to answer his phone this nurse looked at his phone and showed him how to answer it. No other complaints or concerns voiced from patient this visit. Also educated Pt as he is up in his W/C not to be using his feet to make the W/C move as he should not be putting pressure on his wounds.

9/29: pt cooperative, more concerned about his roommate returning from hospital facility cg unavailable this visit, written comm to ALF re SNF and wound care performed encouraged pt to have assist with bathing to avoid feet/dressing getting wet- facility communication updated to reflect this recommendation.

10/01: pt expresses concern of Tom Finn, NP visit on Friday. encouraged that no changes in wound, reviewed wound obs and tx for R plantar foot. pt stated that Starlin warned pt of room placement based on walker use and that he would need to change rooms if he continue using wc. Reminded pt that this is not a normal practice and if they do this that he should inform his guardian. Enc PT to use wc to help bil feet heal. cg not available this visit, Written comm to ALF left re SNV this date: reminder to enc wc use to maintain NWB status. Guardian to be contacted upon chg of pt status or chg POC; awaiting return call from VM.

10/08: RLE wound deteriorating with minimal blood-tinged purulent drainage; no other s/s infection. PCP notified of findings this date, VM for requested updated wound care (3rd attempt). cg not available this visit, written comm provided to ALF re SNV and wound care. No changes to cg asst or reminders for PT care. ALF informed of wound deterioration. Sent wound assessment info /c pics to Kendra to communicate with HomeMD to facilitate new wound care interventions.

10/10: SN contacted wound NP re Rt plantar wound deterioration; initial contact began 10/6/2025. cg not available this visit, written comm provided to ALF re SNV Have not received guidance from PCP, HHC mgt involved Guardian LM on wound condition and that pcp was notified as well.

10/13: knowledge of fall. Pt denies injuries from fall other than his buttocks are sore. There isn't any redness, swelling, or bruising to back or buttocks. He was unable to tell this nurse how he fell. PCP notified of fall. Wound care performed. Interventions performed - (FT)
Clinician/NP to perform wound care 3x/week using aseptic technique: #2 Left plantar foot diabetic ulcer: clean with wound cleanser, pat dry with gauze, apply Calcium Alginate to wound and xeroform to pink surround, cover with gauze, wrap with kerlix, secure with ace bandage or coban. May discontinue treatment when wound is healed. (FT) Clinician/NP to perform wound care 3x/week using aseptic technique: #1:
Right plantar foot diabetic ulcer: clean with wound cleanser, pat dry with gauze, apply Calcium Alginate to wound and xeroform to pink surround, cover with gauze, wrap with kerlix, secure with ace bandage. May discontinue treatment when wound is healed.

10/15: Pt lying in bed upon arrival. He had called the office 3 times before this nurse s arrival trying to figure out when he would be seen as he was waiting to get his hair cut. This nurse attempted to inform him of arrival time day before visit, but he struggles to use his phone so most likely didn't get message. Wound care

performed. NO S/S infection. Attempted to speak with staff related to Pt s BS and WT this visit. All staff this nurse encountered were unable to assist. Was told by one individual that a med tech would be out to assist, however, after waiting 10 Minutes never showed up. Written update left for staff.

10/20: Upon arrival Pt up in the dining room with his walker which he knows he isn't supposed to WT bear on his feet due to wounds. He is very confused. He has previously been able to note that this nurse is the one that takes care of his feet and today he has no clue. He is slow to speak or articulate words. He has no other S/S stroke or heart attack. No slurred speech, facial drooping, weakness on one side. When asked if he could return to his room for visit he just stared and then said I was just waiting for dinner . Let him know that it was not time yet and visit would be done before dinner. Still took asking multiple times for him to finally decide he could return so his feet could be cared for. He also had no idea where his W/C was and he wasn't sure how to get back to his room. While walking back he said i just feel like I am going to pass out. Had already asked staff to obtain a BS and they ignored request. Was by a staff area when he said this and this nurse yelled in to the lady in room to get a chair she said she didn't have one. Asked her what about one of the ones stacked against the wall could she bring one so this patient didn't fall. Again asked for his BS to be checked. Staff was very short and not real willing to help with this situation. Finally got them to obtain a BS and it was within range. Was able to return patient to his room and assisted him to his bed. Wound care performed. BP on the high side but has been in previous visits. Pt denies chest pain, not visibly SOB, or headache, or blurred vision. Denied need for EMS. there was not any leadership present during this visit for this nurse to voice concerns. Spoke with staff that was present. This nurses error was not aware Pt had a guardian so did not notify of condition. Notified PCP office.

10/22: In room lying in his bed and agreeable to visit. Pt does not appear to be confused this visit. He knew that this nurse was there to take care of his feet. Wound care performed. No S/S infection. Staff continues to be unable to obtain and document a daily WT on this patient. Staff continues to blame this on a new system. Unable to connect with Starlin- leadership at facility. It is very difficult to gain information or help at this facility from staff members. He has no other skin issues. He has no S/S respiratory infection. unable to obtain BS from staff as they can t find one in his chart.

10/24: patient found without dressings on this date. In bed and agreeable to visit. Pt reports that his dressings came off with his jeans last night thus no dressings in place when this nurse came for visit. Wound care performed. No s/s infection. No s/s respiratory infection. Encouraged Pt to leave dressings on until Monday's visit and call agency if these dressings come off as we can do a PRN if needed. No confusion both today.

10/27: Pt in his bed and agreeable to visit. Wound care performed. Dressings off both feet upon arrival. Pt doesn't know why they are off. Educated Pt that dressings

need to stay on to help prevent infection. Right foot is reddened and warm to touch. PCP made aware and wound images sent to their office during this visit. Spoke with Daletron, executive director at facility before leaving facility to let her know that left foot suspicious for infection and he is a little confused. M Barnett @ PCP has been made aware with no further directions given at this time. Daletron also reached out to PCP and said if they didn't respond soon that she would send the Pt to be seen in the ED. Patient in no s/s of immediate distress at end of visit. Will follow up with facility/PCP to office determine plan of treatment for patient. Pt is a little confused this visit. PCP office aware. He denies HA, nausea, fatigue, or muscle cramps. Spoke with Daletron today regarding interactions with staff during previous visits: Unable to get help when needed whether it be for information on patient or actual help with the patient during episode of weakness and confusion. Also WT s not being available to help with assessing if Pt has excess fluid on board.

10/27/25: Kim Scott, LPN asked for assistance of this RN to determine if a wound care referral had been sent for patient. Kim communicated to this RN that since Tom Finn, NP has been gone from Home MD, it did not appear that patient has not been seen by a wound provider. S/S of infection and worsening wounds were reported to the providers office by LPN Kim Scott this date This RN contacted Mendota wound clinic to follow up about wound care referral that was placed by Home MD. This RN was told by Mendota that they had left a voicemail with Home MD about not accepting his referral and they did not get a call back. This RN then communicated with Home MD office to report that this RN confirmed with Mendota that they did not accept patient's referral. This RN asked Home MD if they planned on putting another wound care referral in for another provider. AJ with Home MD responded that a referral was also placed to Rebirth Advanced Healing and, per her wound care department, other referrals made to other sources have also declined his referral. This patient was sent to the ED on 10/27/25 and was admitted for sepsis. Will follow patient upon his return back home."

I reviewed Resident A's service plan. The service plan read,
"(Resident A) uses walker and wheelchair. (Resident A) has walker but Interim and PCP doesn't want him waking at this time due to wounds on his heels. Med tech can cover wound with gauze and wrap with kerlix if it get soiled or comes off and contact DOW if so Interim can be contacted."

I reviewed Resident A's medication administration record (MAR). The MAR read,
"Wound Care: if dressing comes off clean with Saline apply gauze and wrap with Kerlix and contact DOW so she can contact Interim."

I reviewed Resident A's hospital discharge paperwork from 08/31/2025. The paperwork revealed Resident A was to follow up with his nurse practitioner.

I reviewed Resident A's Home MD physician paperwork. The paperwork revealed Resident A was seen by his visiting physician on 09/05/2025. On this date a referral was sent to podiatry and home health care.

I reviewed Resident A's podiatry visit paperwork. The paperwork revealed Resident A was seen by Thomas Finn, DNP on 09/04/2025. The instructions on this paperwork read,
"HHC SN to visit 2-3x/weekly. Provider to visit q2 weeks on Friday. Podiatry appt not needed at this visit."

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 and review of documentation revealed Resident A was to be non-weight bearing and had orders for wound care in which Interim Home Care was to be contacted if the wound dressings came off. Review of Interim Hospice Documentation revealed there were multiple instances in which Resident A was found to be ambulating with his walker and was found with no dressings on his wounds. The facility failed to provide care that was consistent with Resident A's service plan.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

Kimberly Horst 12/08/2025

Kimberly Horst Date
Licensing Staff

Approved By:

Andrea L. Moore 12/23/2025

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