GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

July 29, 2024

Anna Hinton
Pioneer Resources
1145 Wesley Ave.
Muskegon, MI 49442

RE: License #:	AS610077781
Investigation #:	2024A0356039
	Sheridan AFC

Dear Ms. Hinton:

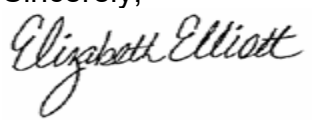
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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
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 #:	AS610077781
Investigation #:	2024A0356039
Complaint Receipt Date:	06/10/2024
Investigation Initiation Date:	06/10/2024
Report Due Date:	08/09/2024
Licensee Name:	Pioneer Resources
Licensee Address:	1145 Wesley Ave. Muskegon, MI 49442
Licensee Telephone #:	(231) 286-8637
Administrator:	Anna Hinton
Licensee Designee:	Anna Hinton
Name of Facility:	Sheridan AFC
Facility Address:	4144 Sheridan Drive Muskegon, MI 49444-4341
Facility Telephone #:	(231) 773-5355
Original Issuance Date:	02/15/1998
License Status:	REGULAR
Effective Date:	08/15/2022
Expiration Date:	08/14/2024
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A sustained injuries and staff do not know how the injuries were obtained.	Yes

III. METHODOLOGY

06/10/2024	Special Investigation Intake 2024A0356039
06/10/2024	Special Investigation Initiated - Telephone Licensee Designee, Anna Hinton.
06/12/2024	Inspection Completed On-site
06/12/2024	Contact - Face to Face Anna Hinton, LD, Ashley Williams, staff, Diane Nelson, staff, Justin Bartee, staff, Resident A, Resident B.
06/12/2024	Contact - Document Received IR's (Incident Reports).
06/13/2024	Contact - Document Received Facility documents received.
07/02/2024	Contact - Telephone call made. DCW's Donell Liles, Rose McDaniel.
07/02/2024	Contact - Telephone call made. Health West supports coordinator, interviewed Janice Schalk. HW nurse, Cassie Pierce, left mess.
07/02/2024	APS Referral Centralized Intake referral made.
07/25/2024	Contact-Telephone call made. Cassie Pierce, Health West RN.
07/29/2024	Exit Conference-Licensee Designee, Anna Hinton.

ALLEGATION: Resident A sustained injuries and staff do not know how the injuries were obtained.

INVESTIGATION: On 06/10/2024, I received an emailed report from Fruitport Police Officer Joshua Wise. Ofc. Wise wrote that the ambulance staff seemed concerned with the number of head injuries Resident A had and the inability on the staffs' part to explain where they came from. Ofc. Wise attached a copy of his police report. Ofc. Wise's report documented the following information: *'On 06/04/2024, Ambulance assist, I was dispatched to an assault with injuries at 4144 Sheridan Dr. which is an adult foster care home within Fruitport Township. Upon arrival on scene, I was advised that (Resident B) had pushed (Resident A) aside while he was trying to get into his room. (Resident A) ended up falling and hitting his head.*

(Resident A) had a visible injury on the home of his head (sic) Trinity Health EMS (emergency medical service) and Fruitport Fire responded. Trinity Health EMS transported (Resident A) to Trinity Health Hospital for treatment.

I asked staff if they believed there was any criminal intent from (Resident B) when this happened. Staff advised it was completely accidental and there was no criminal intent from (Resident B). They advised he was just trying to get past (Resident A) to get in his room.

Trinity Health EMS staff did point out a number of head injuries on (Resident A) and they appeared concerned with them (they counted at least three prior injuries other than the one from this incident). Staff advised they had no idea how they had happened and advised (Resident A) is mobile and gets around on his own, but he falls all the time, and they presumed the injuries were from that. Disposition: Closed. No criminal intent. Turned over to the State of Michigan regulatory officials for review.'

On 06/12/2024, I conducted an inspection at the facility and met Licensee Designee, Anna Hinton at the facility. Ms. Hinton stated the home manager, Yvette Stuckey has been off work on leave since 05/30/2024 and she has been assisting in covering duties at the facility. Ms. Hinton stated Resident A falls often and acknowledged on 06/03/2024, Resident B pushed Resident A, Resident A fell and went to the hospital. Ms. Hinton stated she noticed old marks on Resident A's forehead that staff never informed her of, and she is not exactly sure how they occurred but that they are most likely due to falls Resident A had in the facility. Ms. Hinton stated she worked on 06/02/2024 and noticed the marks on Resident A's forehead. She did not find an IR (incident report) with information regarding Resident A's injuries, so she wrote an IR on 06/03/2024. Ms. Hinton added on 06/01/2024, DCW (direct care worker) Tyesha Stewart worked 2nd shift (3:00p.m.-11:00p.m.) and she did not notice any marks or injuries on Resident A's forehead at that time. Ms. Hinton stated if true, this leads her to think the injury/injuries occurred on 3rd shift (11:00p.m.-7:00a.m.) on 06/01/2024 or 1st shift (7:00a.m.-3:00p.m.) on 06/02/2024. Ms. Hinton stated Resident A fell again on 06/11/2024 and DCW Ashley Williams called the Health West on-call nurse and was instructed to begin the head injury protocol, but she (Ms. Hinton) realized that while Ms. Williams began the head injury protocol with Resident

A, the staff on the following shift did not follow the protocol due to a confusion on what to do and how to document it.

On 06/12/2024, I observed Resident A sitting at the dining room table drinking a cup of coffee. Resident A has visible injuries on his forehead. One injury is directly in the middle of Resident A's forehead and appears to have a small pink in color, skinned area with a yellowing, older appearing, bruise underneath the injury. The other marks on Resident A's forehead are a red mark near his hairline at the top of his forehead and a red mark above his left eye. I also observed a scabbed over injury on the back of Resident A's head from the fall that sent him to the ER (emergency room). Resident A is unable to provide pertinent information to this investigation due to cognitive deficits.

On 06/12/2024, I attempted to interview Resident B in his room at the facility. Resident B is unable to provide pertinent information to this investigation due to cognitive deficits.

On 06/12/2024, I interviewed DCW Justin Bartee, part time 1st shift staff. Mr. Bartee stated he does not remember seeing the marks on Resident A's forehead or when they occurred. Mr. Bartee stated he does not know what happened to Resident A to leave those marks.

On 06/12/2024, I interviewed DCW's Ashley Williams and Diane Nelson at the facility. Ms. Williams and Ms. Nelson work 2nd shift and stated an IR was written about the mark on Resident A's forehead that is located at the top of his forehead and there is an IR written covering the injury to the back of Resident A's head when Resident A went to the ER. Ms. Williams and Ms. Nelson did not know how the older bruise in the middle of Resident A's forehead got there nor do they know how the newer looking red mark above Resident A's left eye happened. Ms. Williams and Ms. Nelson stated Resident A falls and that is likely how the injuries have occurred.

On 06/12/2024, I received and reviewed an IR dated 06/03/2024, written and signed by Anna Hinton. The IR documented the following information, *'On 06/02/2024 this writer worked 2nd shift at Sheridan. I noticed that (Resident A) has some abrasions on his forehead. As I have been on call for Sheridan since 05/30/2024 and had received no notice of any injury from home staff, I assumed whatever had caused the abrasions had already been reported. On 06/03/2024, I worked with Tyesha Stewart, and Tyesha asked me what happened to (Resident A's) forehead, and said she had worked 2nd shift on 06/01/2024, and he did not have those marks. If this is correct, the injury must have occurred between 3rd shift on 06/01/2024 and 1st shift on 06/02/2024. I checked for an incident report and through his progress notes but found no notice of an injury. I called Cassie Pierce, RN and left a message informing her of the issue and that an IR was being written. (Resident A) had not exhibited any obvious signs of head injury when I worked on 06/02/2024 and there was no notice of any issues from home staff. A memo was posted to staff asking for information regarding this incident. Memo also included a reminder that injuries must be*

immediately reported. Even though the incident apparently occurred over 24 hours ago, I requested that each shift for the next 24 hours record on the head injury form once per shift and if any issues were noted to contact me.'

On 06/12/2024, I received and reviewed an IR dated 06/04/2024, written by Ms. Hinton, and documented staff present as Ashley Williams and Tyesha Stewart. The incident occurred on 06/03/2024 at 9:00p.m. The IR documented the following information, *'Both staff heard a loud noise. They went down the bedroom hallway and found (Resident A) lying on his back on the floor in the doorway of (Resident B's) bedroom. (Resident C) told staff that (Resident B) pushed (Resident A). Both staff checked (Resident A) for injury and found blood coming from his scalp (back of head). Staff contacted on-call RN who said for him to go to ER. Staff called for an ambulance as he was unsteady, and the home vehicle does not have wheelchair hookup. (Resident A) is unsteady, and he likes to walk around a lot. The team is in process of getting him a safety helmet.'* There also is an IR written by Ms. Williams and signed by Ms. Hinton on a Health West IR form that documented the same information.

On 06/13/2024, Ms. Hinton provided me with the Head injury protocol memo she posted for the staff on 06/12/2024 after she discovered there was confusion among staff on completing the head injury protocol. The memo laid out the following instructions: *'Apply first aid, if needed, contact the RN, contact the PR on-call person, follow the instructions given, this will include completing an Incident Report, and completing 24 hours of the "Head Injury Protocol" form. The Head Injury Protocol includes checking "Neuro/Wellness Checks (alert, verbal, pupils, gait, mood) at varying intervals It also includes taking the person's "vitals" (blood pressure (BP), temperature, pulse and respirations (the number of times person takes a breath in one minute), if a check changes from the last one completed, contact the RN/PR on-call person, this protocol must be completed as written, and goes for 24 hours from the first check to the last. Please review the attached "Head Injury Protocol Documentation" form. One last note: The "Head Injury Protocol Documentation" form is NOT the same as the Body Check form we started – the Body check form is to be completed on first and second shift daily, for all residents who are assisted with dressing/undressing, toileting, and bathing. Reminder that any injury "above the neck" is considered a "Head Injury".'*

In addition, Ms. Hinton provided me with the head injury protocol documentation form that staff are supposed to fill out after calling the on-call nurse and being instructed to follow the head injury protocol. Staff are required to document 15-minute checks for the first hour, then hourly checks, then every 4-hour checks and this goes on for 24 hours after an injury occurs. Staff are required to document 'time, initials, alertness, gait, pupils, mood and verbal' after contacting the facility nurse and documenting the injury.

On 06/13/2024, I received and reviewed the assessment plan for Resident A dated 04/1/2024. The assessment plan documented that Resident A does not require staff

assistance with walking or mobility and described Resident A as, *'walks in a slumped position.'* The assessment plan documented no assistive devices that Resident A uses for mobility and/or walking and documented that Resident A has difficulty walking on uneven surfaces and going up and down stairs (there are no stairs in the facility).

On 06/13/2024, I received and reviewed the assessment plan for Resident B. Resident B's assessment plan documented that Resident B controls aggressive behavior and he is very friendly and gets along well with others.

On 06/13/2024, I reviewed an IR dated 06/11/2024 at 6:41p.m., written by Ms. Williams and signed by Ms. Hinton. The IR documented the following: *'(Resident A) was walking in the living room when he was trying to turn himself around in another direction. He lost his balance and fell to the ground. He hit his head on the wall. Staff checked him for any visible injuries or bruises, his vitals were taken, I called the on-call nurse, I was instructed to follow the head injury protocol, to monitor (Resident A) for any changes in his baseline and administer Tylenol for pain. I also called the interim house manager.'*

On 07/02/2024, I interviewed DCW Donell Liles, 3rd shift staff via telephone. Mr. Liles stated he has worked at this facility for 7 years and that Resident A has not fallen out of bed "when I have been on 3rd shift." Mr. Liles stated Resident A falls often, he should not be walking unassisted and should have rails on his bed because he (Mr. Liles) often sits in the hallway during 3rd shift to monitor and make sure Resident A does not fall out of bed during nighttime hours. Mr. Liles stated that Resident A is able to walk but he is unsteady on his feet, that he (Mr. Liles) does not recommend that Resident A walk on his own. Mr. Liles stated Resident B can walk, is nonverbal and is never in a bad mood and he (Mr. Liles) has never seen Resident B use any form of violence on another resident including Resident A. Mr. Liles stated Resident A usually falls on 2nd shift, there are no staff or residents in the facility harming Resident A, "he is falling." Mr. Liles stated Resident A needs padding on the floor near his bed, bed rails and a bed that is low to the floor to prevent injuries from a fall from his bed. Mr. Liles stated he followed the head injury protocol on Resident A for 2 days after this last incident. Mr. Liles explained there was a book laid out in the kitchen with paperwork for each resident including Resident A and he documented in the book for Resident A for two days after his fall. However, Mr. Liles stated they "just got that out" to document head injury protocols for Resident A.

On 07/02/2024, I interviewed DCW Rose McDaniel, 1st shift staff via telephone. Ms. McDaniel stated that Resident A's balance is very unsteady, he walks fast, leans forward and falls do occur. Ms. McDaniel stated the first injury to Resident A's forehead occurred when Resident A fell out of his bed and stated this was "months ago." Ms. McDaniel stated the second injury to Resident A's forehead was a cut from a fall and Cassie Pierce, Health West nurse came to the facility and looked at the injury on Resident A's forehead. Ms. McDaniel stated she heard that Resident B pushed Resident A down because Resident A was in Resident B's bedroom causing

the injury to the back of Resident A's head. Ms. McDaniel stated they have a helmet, gait belt and hi-lo bed for Resident A but he continues to fall and mainly, "he falls out of the bed." Ms. McDaniel stated staff "get busy" and it is "hard to keep him from falling." Ms. McDaniel stated Resident A walks all the time and he is not steady at all. Ms. McDaniel stated the head injury protocol was followed three different times following the injuries Resident A sustained to his forehead x2 and the back of his head.

On 07/02/2024, I interviewed Health West case manager, Janice Schalk via telephone. Ms. Schalk stated Resident A is falling a lot They have fitted Resident A for a helmet and are in the process of getting him a hi-lo bed and a mat on the floor. Ms. Schalk stated staff at the facility should be using a gait belt on Resident A due to knowledge that he falls often. Staff at the facility were in-serviced on head injury protocols early in May 2024, before any of these incidents occurred so staff should have known how to complete the head injury protocol. Ms. Schalk stated staff have been re-in serviced on head injury protocol and hopefully the assistive devices will prevent future falls and injury for Resident A.

On 07/25/2024, I interviewed Cassie Pierce, Health West RN (registered nurse) via telephone. Ms. Pierce stated she is not familiar with the specific incidents that caused injuries to Resident A's head and that they are still working on the assistive devices for Resident A. Ms. Pierce stated the on-call nurse should always be notified each time there is a fall and an injury such as Resident A's. Ms. Pierce stated head injury protocol was supposed to start after the injury was sustained and last for 24 hours after the injury, and staff at the facility did not follow the protocol nor did staff seem to know about head injury protocol. Ms. Pierce stated staff have been retrained and should know how to conduct and document head injury protocol when told to complete the protocol by medical personnel.

On 07/29/2024, I conducted an exit conference with Anna Hinton, Licensee Designee via telephone. Ms. Hinton acknowledged that staff did not follow the head injury protocol as directed by the facility nurse. Ms. Hinton stated staff have been retrained and are knowledgeable on the proper monitoring and documenting of the head injury protocol. Ms. Hinton stated she continues to work on getting assistive devices in place to prevent future falls for Resident A. Ms. Hinton stated she understands the information, analysis, and conclusion of this applicable rule and will submit an acceptable corrective action plan.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(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.

ANALYSIS:	The complainant reported multiple injuries were noticed on Resident A's forehead and head and staff were not able to tell police or EMS what happened. Based on investigative findings through staff interviews, a review of IR's and facility documents, there is a preponderance of evidence to show that Resident A's protection and safety have not been maintained at the facility due to several falls with injury, the lack of knowledge of what happened and follow through on head injury protocol and prevention. Therefore, a violation of this applicable rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

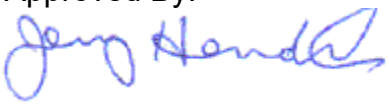
IV. RECOMMENDATION

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

07/29/2024

Elizabeth Elliott Date
Licensing Consultant

Approved By:



07/29/2024

Jerry Hendrick Date
Area Manager