GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 9, 2024

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

RE: License #:	AS610237359
Investigation #:	2024A0356049
	Riverwood

Dear Ms. Hinton:

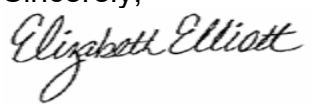
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 #:	AS610237359
Investigation #:	2024A0356049
Complaint Receipt Date:	07/26/2024
Investigation Initiation Date:	07/26/2024
Report Due Date:	09/24/2024
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:	Riverwood
Facility Address:	2743 S Riverwood Twin Lake, MI 49457
Facility Telephone #:	(231) 773-5355
Original Issuance Date:	08/08/2001
License Status:	REGULAR
Effective Date:	02/20/2024
Expiration Date:	02/19/2026
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A was injured, and care was not obtained immediately.	Yes

III. METHODOLOGY

07/26/2024	Special Investigation Intake 2024A0356049
07/26/2024	APS Referral Ken Beckman, Muskegon County DHHS, APS.
07/26/2024	Special Investigation Initiated - Telephone Ken Beckman, APS worker, assigned for investigation.
07/31/2024	Inspection Completed On-site
07/31/2024	Contact - Face to Face APS, Ken Beckman, LD Anna Hinton, Home manager, Angela Hicks, DCW's Shallona Bailey, Amber Wawrzyniak.
07/31/2024	Contact - Document Received Facility documents received/reviewed.
07/31/2024	Contact-Telephone call made Sarah Cunningham-Health West RN (nurse).
08/26/2024	Contact-Telephone call made Jessica Sobers-HW nurse.
08/26/2024	Contact-Telephone call made Legal guardian of Resident A.
09/09/2024	Exit Conference-Licensee Designee, Anna Hinton.

ALLEGATION: Resident A was injured, and care was not obtained immediately.

INVESTIGATION: On 07/26/2024, I received a BCAL (Bureau of Children and Adult Licensing) online complaint. The complainant reported Resident A is currently in ER (emergency room) from a fall on 07/20/2024. Resident A was only brought to receive medical attention on 07/24/2024. Resident A's left ankle, left and right feet are broken. Resident A's legs are bruised and swollen. Resident A also has a bruise on her right bicep. Resident A is being admitted to Trinity Health hospital. Adult

Protective Services (APS) worker, Ken Beckman is assigned to investigate this complaint.

On 07/31/2024, I conducted an inspection at the facility with Mr. Beckman. Mr. Beckman and I interviewed Anna Hinton, Licensee Designee and Angela Hicks, home manager at the facility. Ms. Hicks stated Resident A moved into this facility on 06/04/2024 and staff have been getting to know her over the past month and a half. Ms. Hicks and Ms. Hinton stated Resident A tends to seek attention if other residents are getting attention from staff. As an example, Ms. Hicks and Ms. Hinton stated if a resident is unable to feed themselves and staff are assisting that resident to eat, Resident A will want staff to feed her. If a resident is using a wheelchair, Resident A will no longer be able to walk well and will want to use a wheelchair. Ms. Hicks stated on 07/19/2024, Resident A did not act like she was in any pain, nor did she say anything about being in pain, she seemed to be “ok.” Ms. Hicks stated on 07/20/2024, Resident A stated she could not use her legs, yet she got up, walked to the bathroom, then the front room, and sat in a chair. Ms. Hicks stated DCW (direct care worker) Amber Wawrzyniak reported on 07/20/2024, she witnessed Resident A sitting in a chair and then she (Resident A) lowered herself to the floor and said that she fell. Ms. Wawrzyniak reported to Ms. Hicks that she watched Resident A and that she did not fall to the floor but lowered herself from the chair onto the floor. Ms. Hicks stated everything seemed “normal” but then Resident A did fall with Ms. Hicks on 07/20/2024, landing on her buttocks, she did not seem hurt or injured and she said her legs would not work. Ms. Hicks stated Resident A had a small bruise on her ankle, so she gave Resident A Tylenol and Resident A seemed to be fine after that. Ms. Hicks stated she called the on-call nurse at Health West on 07/20/2024 and asked for instructions. The nurse told her if she does not seem to be in “bad pain,” just monitor her and do not take her to the ER, just continue to monitor her. Ms. Hicks stated Resident A complains of back pain often. She does not use a wheelchair and the only time she was in a wheelchair was on 07/20/2024 when she was having trouble standing. Ms. Hicks stated Resident A wore shoes, or slippers and during this time, she got up and went to the bathroom during the night on her own. Ms. Hicks stated she told staff on all shifts what the nurse from Health West said as far as monitoring Resident A and from 07/20/2024-07/24/2024, she did not hear anything from staff stating that Resident A continued to complain of pain. Ms. Hicks stated after her call to the on-call Health West nurse on 07/20/2024, no one else, that she is aware of, called for medical care for Resident A until 07/24/2024.

On 07/31/2024, Mr. Beckman and I interviewed DCW Shallona Bailey, 1st shift staff. Ms. Bailey stated on 07/24/2024, she was getting Resident A ready for the day, got her up and dressed and noticed that her foot was more purple than the day prior (on 07/23/2024). Ms. Bailey stated on 07/23/2024, she noticed Resident A’s ankle was light purple and on 07/24/2024, her foot was noticeably purple. Ms. Bailey reported that Ms. Wawrzyniak saw Resident A “fall”, but she (Ms. Wawrzyniak) described it as Resident A “lowered herself to the ground” and this was on 07/20/2024. Ms. Bailey stated a “light purple” bruise was seen on Resident A’s arm and Ms. Bailey reported it was most likely from staff assisting Resident A up from sitting on the floor. Ms.

Bailey stated on 07/23/2024, she noted a “light purple” bruise on Resident A’s ankle and then on 07/24/2024, Resident A’s ankle was “purple.” Ms. Bailey stated Resident A did not want to get out of bed on 07/24/2024 and staff knows that Resident A likes to stay in bed but, on this date, staff called the on-call Health West nurse and sent Resident A to the hospital. Ms. Bailey is not aware of any other calls to Health West regarding Resident A’s complaints of foot/ankle pain except for the call on 07/20/2024 and when Resident A went to the hospital on 07/24/2024.

On 07/31/2024, Mr. Beckman and I interviewed DCW Amber Wawrzyniak, 1st shift (but works all shifts). Ms. Wawrzyniak stated she worked on 07/20/2024 and Resident A refused to get out of bed. Ms. Wawrzyniak stated she tried to get Resident A up and she refused to get out of bed so Ms. Hicks “took over.” Ms. Wawrzyniak stated on 07/20/2024, Resident A walked from her bed to the bathroom and said, “my legs won’t work” and “my back hurts” but she (Ms. Wawrzyniak) stated she never saw any bruises and there was nothing that would lead her to think anything physically was wrong with Resident A. Ms. Wawrzyniak stated she observed Resident A, on 07/20/2024, “put herself on the floor using her legs and feet” and then claimed she fell but Ms. Wawrzyniak stated she watched her lower herself onto the floor and it was not a fall. Ms. Wawrzyniak stated Resident A had a doctor’s appointment on 07/17/2024 at Fruitport Family Medicine and they checked her back because she told the doctor her back hurt. Ms. Wawrzyniak stated they observed an area of irritation on Resident A’s back where her bra strap clasp was rubbing on her skin but that was the extent of her ailments at that time. Ms. Wawrzyniak stated Resident A did not complain of any other pain and she (Ms. Wawrzyniak) did not notice or see any bruising or wincing due to pain until another staff pointed out the bruising on Resident A’s ankle on 07/24/2024. Ms. Wawrzyniak stated she never called the nurse at Health West because Resident A only complained that her legs wouldn’t work yet she was walking around and never complained of being in pain or talked about her feet hurting to her (Ms. Wawrzyniak) on 07/20/2024.

On 07/31/2024, I interviewed Health West RN (registered nurse), Sarah Cunningham via telephone. Ms. Cunningham stated she was the on-call nurse on 07/20/2024 and she received a telephone call from staff at the facility regarding Resident A. Ms. Cunningham stated staff informed her that Resident A had a witnessed fall to the ground but there was no injury, she did not hit her head and nothing hurt on Resident A. Ms. Cunningham stated staff reported they administered a Tylenol to Resident A and she was doing well. Ms. Cunningham stated she advised staff to monitor Resident A closely and to call if her condition changed. Ms. Cunningham stated staff did not call regarding Resident A’s condition until 07/24/2024.

On 07/31/2024, I received and reviewed an IR (Incident Report) dated 07/20/2024, written by Ms. Hicks and documenting Ms. Wawrzyniak as staff present. The IR documented the following information, *‘(Resident A) was standing up getting dressed and she said that she couldn’t use her legs. I, Angela, started to help assist*

her with dressing and (Resident A) fell to the ground on her butt. Because of the fall, she had a bruise that appeared on her leg a few hours later. Called the on-call nurse and informed her about (Resident A's) morning. On call stated to just keep a close eye on (Resident A) and if she doesn't seem to be in pain to hold off on taking her to the ER.'

On 07/31/2024, I received and reviewed an IR dated 07/24/2024, 10:00a.m., written by Ms. Hicks. The IR documented the following information, *'On 7/24/24, (Resident A) was bearing weight, I noticed a bruise on each one of her ankle/foot. On 07/20/2024 (Resident A) stated that her legs didn't work, and she didn't want to do too much moving without assist from staff. I called on call nurse and she just wanted us to monitor her if she got any worse to take her into ER. Taking her to ER, had x-rays, blood drawn, and urine sample taken.'*

On 07/31/2024, I received and reviewed an IR dated 07/24/2024, 10:00a.m., written by Ms. Hicks and documenting staff present as Shallona Bailey. The IR documented the following information, *'Shallona entered (Resident A's) bedroom to get her up for the day and realized that (Resident A) had a big bruise on her right foot. Shallona called for me (Ms. Hicks) to check it out. When I entered the room, I noticed that (Resident A) had a bruise on her left foot that was not there the day before. I called her nurse and she suggested to take (Resident A) to ER. Helped (Resident A) get dressed and transferred in a wheelchair and was taking to ER. After (Resident A's) results from test came back, (Resident A) had a broken foot and broken ankle. She will be having surgery for ankle; Doctor is just going to wrap her broken foot and said it will heal on its own. Physical injury apparent, bruise occurred later.*'

On 07/31/2024, I received and reviewed the Consumer Progress Notes dated 07/20/24-07/24/24 written by staff during their shifts at the facility. The notes documented the following information:

- 7/20-1st shift- *'She got up at 10:30a.m., very agitated and saying her "legs won't work" so she is in her chair. Other than that, good day.'* Written by Ms. Wawrzyniak.
- 7/20-2nd shift- *'Was up in her chair in the living room when staff arrived. Ate dinner and meds. Went to bed at 6p.m. no other concerns.'* Written by DCW Rochelle Skiniski (sp?).
- 7/20-3rd shift- *'Was asleep when staff arrived and stayed asleep all night with no concerns.'* Written by Ms. Skiniski.
- 7/21-1st shift- *'(Resident A) did not want to get out of bed today. She wanted staff to call 911 because she did not want to get up. (Resident A) would not do what was asked of her today. She would not sit up and was refusing to change into a dry brief. (Resident A) just wanted to lay in bed all day. Several prompts were given to (Resident A) to get her to put her clothes on. No other issues or concerns.'* Written by DCW Demetrius Burks.
- 7/21-3rd shift- *'(Resident A) was sleep all night, no concerns.'* Ms. Wawrzyniak.

- 7/22-1st shift- *'Woke at 10 refused b-fast and lunch. Had all (indecipherable). Refused to get out of bed.'* Ms. Wawrzyniak.
- 7/22-2nd shift- *'(Resident A) was in bed at start of shift started to cry because I got her up to toilet her, she refused to get dressed, stated she wanted to lay back down, laid down, liquids given, back asleep, 8p.m., took meds, ate 10% of food, drank liquids, brief changed with help, asleep.'* Written by DCW, Artrianna Jackson.
- 7/22-3rd shift- *'(Resident A) was in bed when I arrived, slept through the night.'* Written by DCW Shallona Bailey.
- 7/23-1st shift- *'(Resident A) refused to get out of bed when I tried helping her, she screamed and said she was hurting, staff tried 3 times during 1st shift.'* Ms. Bailey.
- 7/23-2nd shift- *'(Resident A) not dressed upon arrival. Staff could not redirect her. Both ankles are bruised and swollen. Some crying and wanting to call 911. On the floor several times. Not falls, purposely got on the floor. Ice pack given for ankles and ankles elevated. No other issues for concerns.'* Ms. Burks.
- 7/23-3rd shift- *'(Resident A) was asleep when staff arrived. She stayed asleep throughout the night. No other concerns.'* Ms. Skiniski.
- 7/24-Resident A went to the hospital.

On 07/31/2024, I received and reviewed the LMES (Lake Michigan Emergency Specialists) Emergency Department medical report, dated 07/24/2024, by Dr. Veronica Wilson, DO. The report documented the following information regarding Resident A's diagnosis. *'This 62-year-old female presents from her AFC home for refusal to walk. She had a fall on Saturday. According to caretaker she was just getting her dressed when all of a sudden, she looks like she fell to the ground, she did not lose conscious or appeared to have passed out. She did not hit her head. However, since that time she started to complaint of pain all over. This is not an uncommon thing for her to do at her baseline so there was not much consideration put to it. However, over the last couple days it appears the patient has not been wanting to walk. She has been refusing to bear weight on both of her lower extremities so they brough her in for further evaluation. Her left leg appears bruised from the mid shin down to the ankle and her right foot appears bruised. She comes in tachycardic. She is verbal but does not speak in full sentences, so history is otherwise limited.'* The report then documents*, 'It appears the patient has multiple metatarsal fractures on the right side with a possible Lisfranc injury, also suggesting a bimalleolar fracture and a posterior dislocation of the tibiotalar joint with probably also a minimally displaced fracture of the distal second through fifth metatarsals and the proximal first metatarsal, however, it is reported by the radiologist that the osteopenia makes the nondisplaced fracture evaluation difficult. After consent was obtained by (Relative #1), the patient's legal guardian, we did perform a closed reduction of the left ankle and both the left ankle was splinted as well as the right foot. Dr. Ross is agreeable to admit for orthopedic surgery with internal medicine consultation. She was given medication to take for pain which did reduce her presenting tachycardia. And she was admitted in improved condition.'*

On 08/26/2024, I interviewed Relative #1, Resident A's relative and legal guardian via telephone. Relative #1 stated he got a call on 07/24/2024 from a staff member at the facility and they informed him they (staff) had been trying to get permission from Health West nursing to send Resident A to the hospital, but the Health West nurse would not allow it and alluded that Resident A was "faking" injury to get attention. Relative #1 stated staff informed him that they had been trying to get Resident A up and out of bed for a few days, but she kept "crumbling" to the ground. Relative #1 stated Resident A "does not do that" as a behavior or for attention. Relative #1 stated Resident A does want equal attention as the other residents get but she will not go to this extent to fake injury just to get staff attention and she would never keep that up for three days if she were pretending to be injured. Relative #1 stated Resident A's ankle is broken on one leg and on the opposing foot, her metatarsals are broken. Relative #1 stated Resident A did not use a walker, wheelchair or cane prior to this incident. Relative #1 stated the first time he spoke to staff at the facility regarding Resident A's condition was on 07/24/2024. Staff called him to report they had been trying to get Health West to allow them to send Resident A to the hospital and that Resident A had more than one fracture to her feet and was in the hospital. Relative #1 stated he is upset about this incident and staff at the facility were trying to get the Health West nurse to allow them to send Resident A to the hospital, but it took days.

On 08/26/2024, I interviewed Jessica Sobers, Health West RN via telephone. Ms. Sobers stated a call was answered by on the call nurse, Ms. Cunningham on 07/20/2024. The notes from that call indicate that on Saturday 07/20/2024, Resident A had a staff witnessed fall but she was not hurt, Tylenol was administered, and staff was instructed to observe her and if anything changed, to call the on-call nurse back for further instructions. Ms. Sobers stated on 07/24/2024, nurse Kylie Meloche received the next call from staff at the facility. Resident A was struggling to walk and in pain, there was bruising on both feet, a recommendation was made to send Resident A into ER (emergency room) for evaluation and treatment. Ms. Sobers stated the first call from staff came in on 07/20/2024 and the next call from staff was on 07/24/2024 and there were no calls in between.

On 09/09/2024, I conducted an exit conference with Anna Hinton, Licensee Designee via telephone. Ms. Hinton stated she understands the information in the report, the analysis and conclusion of this applicable rule. Ms. Hinton stated an acceptable corrective action plan will be submitted which will include updated staff training.

APPLICABLE RULE	
R 400.14310	**Resident health care.**
	(4) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a group home shall obtain needed care immediately.

ANALYSIS:	The complainant reported Resident A fell on 07/20/2024 and did not receive medical attention until 07/24/2024. Resident A's left ankle, left and right feet are broken. Resident A's legs are bruised and swollen. After interviews with facility staff, Health West nurses, Relative #1, a review of staff daily progress notes and the ER medical report, there is a preponderance of evidence to show that on 07/20/2024, Resident A began to exhibit symptoms of injury, Resident A complained, cried, requested 911 or refused to get out of bed from 07/20/2024-07/24/2024. Staff called on call nursing on 07/20/2024, was told to monitor Resident A and staff did not seek medical guidance again until 07/24/2024 even though Resident A requested staff call 911 as noted in daily progress notes. Based on investigative findings, a violation of this applicable rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

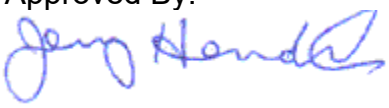
IV. RECOMMENDATION

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

09/09/2024

Elizabeth Elliott — Date
Licensing Consultant

Approved By:



09/09/2024

Jerry Hendrick — Date
Area Manager