



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

November 14, 2024

Susan Griswold
17600 W. River Drive
Morley, MI 49336

RE: License #: AF540339557
Investigation #: 2025A1029002
River View

Dear Susan Griswold:

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 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 (231) 922-5309.

Sincerely,

A handwritten signature in black ink that reads "Jennifer Browning". The script is cursive and fluid, with the first letter of each word being capitalized and prominent.

Jennifer Browning, Licensing Consultant
Bureau of Community and Health Systems
browningj1@michigan.gov - 989-444-9614

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AF540339557
Investigation #:	2025A1029002
Complaint Receipt Date:	10/08/2024
Investigation Initiation Date:	10/08/2024
Report Due Date:	12/07/2024
Licensee Name:	Susan Griswold
Licensee Address:	17600 W. River Drive, Morley, MI 49336
Licensee Telephone #:	(231) 856-7621
Name of Facility:	River View
Facility Address:	17600 W. River Drive, Morley, MI 49336
Facility Telephone #:	(231) 307-3087
Original Issuance Date:	06/27/2013
License Status:	REGULAR
Effective Date:	12/27/2023
Expiration Date:	12/26/2025
Capacity:	4
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED TRAUMATICALLY BRAIN INJURED

II. ALLEGATION(S)

	Violation Established?
Resident A did not receive adequate dental care because he missed a dental appointment in August 2024 and was admitted to the hospital and became septic in October 2024.	Yes
Additional Findings	Yes

III. METHODOLOGY

10/08/2024	Special Investigation Intake 2025A1029002
10/08/2024	Special Investigation Initiated – Telephone call to Guardian A1
10/09/2024	Contact - Telephone call made to Michelle Summit CMH case manager
10/09/2024	Contact - Document Received from CMH Ms. Summit
10/17/2024	Inspection Completed On-site - Face to Face with licensee Susan Griswold and Resident A at River View AFC
10/22/2024	Contact – Telephone call to Preference Dental, sent request for dental records to Ms. Lyndsey.
10/23/2024	Contact - Telephone call received from Ms. Lyndsey
10/24/2024	APS Referral made to Centralized Intake
10/29/2024	Contact - Telephone call made to MI Community Dental Center in Big Rapids and Andrew Castillo APS
11/04/2024	Contact - Telephone call made to MI Community Dental Center
11/07/2024	Contact - Telephone call made to Andrew Castillo APS worker
11/07/2024	Contact – Email to Susan Griswold
11/13/2024	Contact – Telephone call to CMH Michelle Summit, Left message. Sent email.
11/13/2024	Exit conference with licensee Susan Griswold

ALLEGATION: Resident A did not receive adequate dental care because he missed a dental appointment in August 2024 and was admitted to the hospital and became septic in October 2024.

INVESTIGATION:

On October 8, 2024 a complaint was received alleging Resident A did not receive adequate dental care because he missed a dental appointment in August 2024 and was admitted to the hospital and became septic in October 2024. According to the complaint allegations, Resident A had not seen a dentist in months before the missed dental appointments. According to the complainant, licensee Ms. Griswold did not have verification of dental visits or a reason why he missed the appointments.

On October 8, 2024, I interviewed Guardian A1 who stated Resident A has resided in this AFC family home for 4-5 years and he has not had any concerns regarding Resident A's medical needs being met. Guardian A1 stated Ms. Griswold manages all his doctor's appointments and administers his medications and he only pays the bills for Resident A. Guardian A1 stated he received a letter regarding a missed dental appointment in August 2024 but he did not know why it was missed. Guardian A1 stated he heard Resident A was having more gastrological issues lately instead of dental issues. Guardian A1 stated Resident A had dentures in the past but up until a couple months ago, he did not realize there was an issue. Guardian A1 stated he learned there was some decay because food was getting stuck under Resident A's dentures. Guardian A1 does not believe the reason he is in the hospital has anything to do with missing a dental appointment however, he does not have regular contact with Resident A's physician or dentist.

On October 17, 2024, I completed an unannounced onsite investigation at River View and interviewed licensee Susan Griswold. Ms. Griswold stated she had tried to reach out to dental providers and schedule an appointment but she did not have any success. Ms. Griswold did not have any verification of phone calls to schedule these appointments. Ms. Griswold stated she reached out to Preference Dental in Big Rapids and MI Community Dental Centers in Big Rapids for appointments for Resident A. Ms. Griswold stated she knew Resident A was having pain in his mouth for about three weeks but did not know the severity of it until she took him to the hospital. Ms. Griswold stated she knew Resident A had an infected tooth. Ms. Griswold stated Resident A kept telling her that his gums hurt but there was no blood so she notified Guardian A1 but did not make a dental appointment. Ms. Griswold stated Guardian A1 will pay for the appointments but she always schedules them for Resident A. Ms. Griswold stated she does not know when his mouth started to hurt or when she called dental providers or Guardian A1 because she did not document that information. Ms. Griswold stated she notified Resident A's CMH case manager, Michelle Summit on an unknown date about Resident A's tooth pain. Ms. Griswold stated Resident A had a follow up appointment on October 14, 2024 after the hospitalization and Dr. Shafer from Preference Dental extracted Resident A's infected tooth. Ms. Griswold stated Resident A missed a doctor's

appointment in August 2024 because he had gone to the dentist previously at Preference Dental before on an unknown date however she did not have verification of this appointment or know where it occurred. Ms. Griswold did have documents in Resident A's resident record titled *Home Provider Monthly Reports* completed for Community Mental Health – Central MI (CMHCM) however there was no information regarding dental visits.

During the on-site investigation, I reviewed Resident A's resident record. I reviewed the following documentation:

1. *After Visit Summary* from the Corewell Health Big Rapids hospitalization from October 7-October 10, 2024 for a dental abscess. The aftercare instructions included following up with a primary care physician and an outpatient referral to Oral Maxillofacial Surgeon.
2. Resident A was prescribed Amoxicillin after the hospitalization and I verified on Resident A's *Medication Administration Record (MAR)* this was administered to him for five days following his hospitalization as prescribed.
3. *CMH Home Provider Monthly Report* documenting the October 2024 hospitalization.
4. Resident A's *Health Care Appraisal* did not indicate there were any concerns with his teeth.
5. Resident A's *Assessment Plan for AFC Residents* included documentation Resident A was able to take care of his teeth but needed prompts for personal hygiene.

Ms. Griswold stated she would attempt to obtain records from Resident A's dental appointments for the last year and email them to me. However, on November 7, 2024, I did not receive anything so I sent Ms. Griswold an email requesting her to send this information by November 12, 2024 and nothing was received.

On October 17, 2024 I interviewed Resident A. Resident A stated he was in the hospital because he had problems with his teeth and he is still having issues with them. Resident A stated he would like to go back to the dentist because he was still in pain. Resident A stated he thinks they pulled the tooth out after he left the hospital. Resident A stated he had an infected tooth for almost a month before he was taken to the hospital and had told Ms. Griswold and Guardian A1 more than once he was in pain and wanted a dental appointment. Resident A stated he was not sure why there was a delay in getting treatment. Resident A stated he did have appointments for dental cleanings but he did not recall when or where it was located other than it was by a gas station. Resident A stated he feels Ms. Griswold typically does okay making appointments for him but he was still in pain and wanted to be seen again.

On October 23, 2024, I interviewed Tammy Lyndsey from Preference Dental. Ms. Lyndsey stated there have been no missed appointments for Resident A. Ms. Lyndsey stated Ms. Griswold called to schedule a dental appointment for Resident A for October 30, 2024 which was a follow up appointment after the extraction. Ms. Lyndsey stated

Resident A has only been seen on an emergency basis. Ms. Lyndsey stated Resident A was had one extraction in October 2023 and another one done on October 14, 2024 after his hospitalization. Ms. Lyndsey stated there was “strong urging” from Dr. Schafer that Resident A needed a full dental work up when he was seen in October 2023 and this did not occur and another visit was not completed until after the recent hospitalization. Ms. Griswold scheduled an appointment for October 24, 2024. Ms. Lyndsey stated both the lower and upper right side still needs treatment and X-rays and they will focus on the upper right side during the October 24, 2024 appointment. Ms. Lyndsey stated there have been no regular cleanings with Resident A and there is no other history for him since the October 2023 extraction. Ms. Lyndsey stated it is hard to know how long Resident A was in pain for before this occurred. Ms. Lyndsey stated they are not a Medicaid provider so it is possible he did see another provider for cleanings.

On October 29, 2024, I received a call from Adult Protective Services (APS) Andrew Castillo. Mr. Castillo stated he wanted to determine who was responsible for making the dental appointments for Resident A. Castillo stated Resident A’s guardianship lapsed over a year ago. Mr. Castillo stated Resident A attended the follow up appointment for the dental infection and when he completed his on-site, Resident A reported that he was feeling better. Mr. Castillo stated Ms. Griswold did not have verification of previous appointments or why the appointment in August was not completed. Mr. Castillo stated he will be substantiating the concerns for neglect due to the delay in dental treatment.

On November 4, 2024, I contacted MI Community Dental Center and spoke to Christina to inquire about Resident A’s visits who stated Resident A is scheduled in January 2025 for a new patient exam but there have been no prior visits since 2019.

APPLICABLE RULE	
R 400.1416	Resident healthcare.
	(1) A licensee, in conjunction with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician regarding medications, special diets, and other resident healthcare needs that can be provided in the home.

ANALYSIS:	Resident A reported he had dental pain for almost a month but was not taken to the dentist for treatment until his pain worsened and he was admitted into the hospital with a dental abscess that resulted in sepsis. Resident A had this tooth extracted on October 14, 2024, however, there were no prior appointments addressing this pain before the hospital visit. Ms. Griswold stated there was a delay in receiving treatment because she could not get an appointment and Resident A missed his appointment in August 2024 because he had a prior doctor appointment. There was no documentation of attempts to make an appointment or verification of another appointment during the summer. Both Preference Dental and MI Community Dental both denied they have had regular visits with Resident A and Ms. Lyndsey stated in October 2023, Dr. Schafer wanted him to have a full dental work up due to his dental issues but this did not occur and he did not have an appointment again until after this incident.
CONCLUSION:	VIOLATION ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

On October 17, 2024, I completed an unannounced onsite investigation at River View and interviewed licensee Ms. Griswold. Ms. Griswold stated she did not complete an *AFC Incident / Accident Report* to document Resident A's hospital admission. Ms. Griswold stated she did not know what the *AFC Incident / Accident Report* was and I informed her I would email her a copy which I did on November 7, 2024.

Resident A's CMH case manager Ms. Summit also stated she did not receive an *AFC Incident / Accident Report* regarding the hospitalization from Ms. Griswold and found out he was hospitalized from a CMH nurse.

APPLICABLE RULE	
R 400.1416	Incident notification, incident records.
	Rule 16a. If a resident has a representative identified in writing on the resident's care agreement, a licensee shall report to the resident's representative within 48 hours after any of the following: (b) Unexpected and preventable inpatient hospital admission.

ANALYSIS:	Ms. Griswold stated she did not complete an <i>AFC Incident / Accident Report</i> to document Resident A's hospital admission so it was not available to review during the special investigation. CMH case manager, Ms. Summit also stated Ms. Griswold did not send her an <i>AFC Incident / Accident Report</i> to review.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

Upon receipt of an approved corrective action plan, I recommend no change in the license status.



Jennifer Browning
Licensing Consultant

_____ 11/14/2024 _____
Date

Approved By:



11/14/2024

Dawn N. Timm
Area Manager

_____ Date