



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 13, 2026

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

| | |
|------------------|--------------|
| RE: License #: | AS610419009 |
| Investigation #: | 2026A0356024 |
| | Marcoux Home |

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,

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

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|---------------------------------------|--|
| License #: | AS610419009 |
| Investigation #: | 2026A0356024 |
| Complaint Receipt Date: | 02/23/2026 |
| Investigation Initiation Date: | 02/23/2026 |
| Report Due Date: | 04/24/2026 |
| Licensee Name: | Pioneer Resources |
| Licensee Address: | 1145 Wesley Ave. Muskegon, MI 49442 |
| Licensee Telephone #: | (231) 773-5355 |
| Administrator: | Anna Hinton |
| Licensee Designee: | Anna Hinton |
| Name of Facility: | Marcoux Home |
| Facility Address: | 1465 Marcoux Avenue Muskegon, MI 49442 |
| Facility Telephone #: | (231) 773-5355 |
| Original Issuance Date: | 03/17/2025 |
| License Status: | REGULAR |
| Effective Date: | 09/17/2025 |
| Expiration Date: | 09/16/2027 |
| Capacity: | 6 |
| Program Type: | PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL |

II. ALLEGATION(S)

| | Violation Established? |
|--|-----------------------------------|
| Staff neglected Resident A's needs. | No |
| Resident A had open sores due to lack of care. | No |
| Resident A is not provided with snacks. | No |
| Additional Findings | Yes |

III. METHODOLOGY

| | |
|------------|--|
| 02/23/2026 | Special Investigation Intake 2026A0356024 |
| 02/23/2026 | APS Referral Stephanie Kindle, DHHS, APS worker, Muskegon County. |
| 02/23/2026 | Special Investigation Initiated - Telephone Casey Olson, Health West, Office of Recipient Rights. |
| 02/26/2026 | Inspection Completed On-site |
| 02/26/2026 | Contact - Face to Face Jeff Taylor, DCW, Damiyea Wallace, DCW, Tracy Kroll, program manager. Resident A no longer resides in this facility. |
| 03/02/2026 | Contact - Telephone call made Desiree Luttrull, DCW. |
| 03/06/2026 | Contact - Telephone call made Ebony McDowell, DCW. |
| 03/16/2026 | Contact - Telephone call made Casey Olson, Health West Office of Recipient Rights. |
| 03/17/2026 | Contact - Document Received Facility documents. |
| 04/03/2026 | Contact-Face to Face Former Resident C, Jamie Romanosky, MOKA community supports |
| 04/06/2026 | Contact-Telephone call made |

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|------------|---|
| | DCW Getorra Johnson |
| 04/09/2026 | Telephone call made Kara Kile, Health West Supports Coordinator |
| 04/10/2026 | Telephone call received Suzanne Beckman, HW, RN and Chloe Bayne, Integrated Health Clinic nurse. |
| 04/13/2026 | Exit Conference-Anna Hinton, Licensee Designee. |

ALLEGATION: Staff neglected Resident A’s needs.

INVESTIGATION: On 02/23/2026, I received a LARA-BCHS (Licensing and Regulatory Affairs, Bureau of Community Health Systems) Online complaint. The complainant reported on 02/15 or 02/16/2026, Direct Care Worker (DCW) “Shatara” was supposed to put Resident A to bed. Resident A wears a brief and needs to be changed and cleaned up nightly. Shatara is a 2nd shift worker and refused to put Resident A to bed because she did not want to change her or clean her up. Resident A sat in the hallway for 2 hours crying and screaming. The complainant reported another DCW offered to assist Shatara in getting Resident A ready and into bed, Shatara took Resident A and put her into bed, but she told the other DCW they would have to change her brief and clean her up. The complainant reported when the other DCW entered Resident A’s room, Resident A’s legs were hanging off the bed, and she was sliding to the floor. Resident A had to be calmed down prior to getting changed and tucked into bed.

On 02/26/2026, Licensing Consultant Natasha Grew and I conducted an unannounced inspection at the facility and interviewed Tracy Kroll, program manager. Ms. Kroll stated there are no staff by the name of Shatara but there is staff named Getorra Johnson and she (Ms. Kroll) stated this is most likely who the complainant was referring to. Ms. Kroll stated no one made her aware of the complaint information.

On 02/26/2026, Ms. Grew and I interviewed DCW Damyeya Wallace. Ms. Wallace stated she works 1st shift (6:00a.m.-2:00p.m.) and when she begins her shift Resident A & B’s briefs have been wet because 3rd shift (10:00p.m.-6:00a.m.) staff left changing residents’ briefs for 1st shift staff to do. Ms. Wallace stated she has found Resident A & B’s briefs “soaking wet.” Ms. Wallace stated she worked with DCW Ebony McDowell on the day Resident A & B’s briefs were soaking wet and she and Ms. McDowell gave Resident B a bed bath, changed sheets and washed them. Ms. Wallace reported staff did not comb Resident A’s hair at times or bathe her because Resident A refused to allow staff to provide care.

On 02/26/2026, Ms. Grew and I interviewed DCW Jeff Taylor and Mr. Taylor stated he works 1st shift and that he has worked with Ms. Johnson. Mr. Taylor stated

usually when he gets to work in the morning, Resident A is in her wheelchair and he has found her in soiled briefs “sometimes.” Mr. Taylor stated Resident A would ask him to put her to bed and he has done so without any kind of issue or resistance from Resident A. Mr. Taylor stated when Resident A is angry, she would be able to maneuver her foot off the edge of the bed as described in the allegation. Mr. Taylor stated mainly that he has not found Resident A to have poor hygiene when he gets to work in the morning.

On 02/26/2026, Ms. Grew and I requested to interview Resident A but Resident A moved out of the facility on 02/23/2026. Ms. Grew and I observed Resident B in the facility; she was appropriately dressed and adequately clean and groomed.

On 02/26/2026, Ms. Grew and I interviewed Resident C at the facility. Resident C reported that he did not see or hear Resident A crying or screaming in the hallway unattended by staff nor did he see or hear staff refuse to care for Resident A.

On 02/26/2026, Ms. Grew and I observed Resident D & E in the facility. Both residents are unable to provide information pertinent to this investigation due to cognitive deficits. Resident D & E were appropriately dressed and adequately clean and groomed.

On 03/02/2026, I interviewed DCW Desiree Luttrull via telephone. Ms. Luttrull stated she worked with Ms. Johnson on 2nd shift (2:00p.m.-10:00p.m.) and during this shift, Ms. Johnson told her that she was not going to put Resident A to bed and said that 3rd shift would do it. Ms. Luttrull reported that Ms. Johnson stated she had been working for 8 days in a row and she was not going to deal with Resident A. Ms. Luttrull reported that Ms. Johnson stated that Resident A was asking about an outing and Resident A began to “throw a fit.” Ms. Johnson attempted to put Resident A to bed but she was fighting her (Ms. Johnson) so Ms. Johnson put Resident A in the hallway in her wheelchair. Ms. Luttrull stated Ms. Johnson then “flopped” Resident A on her bed and left so when she (Ms. Luttrull) went in to finish getting Resident A to bed, she observed Resident A with her shoes on, ½ on the bed and ½ off the bed. Resident A was “freaking out” because she had one foot on the ground holding her up. Ms. Luttrull stated she got Resident A calmed down, cleaned up, and into bed.

On 03/06/2026, I interviewed DCW Ebony McDowell via telephone. Ms. McDowell stated there is “no way” that Ms. Johnson treated Resident A in the manner reported in the allegation. Ms. McDowell stated Ms. Johnson would not leave Resident A uncared for, put on her bed in a haphazard manner or leave her in wet briefs. Ms. McDowell stated she has never seen Ms. Johnson leave Resident A or any of the other residents uncared for and has never seen Ms. Johnson treat a resident poorly including Resident A.

On 03/06/2026, I interviewed Casey Olson, Health West, Office of Recipient Rights Officer via telephone. Ms. Olson stated she interviewed Resident A on 03/04/2026 in her new placement. Ms. Olson stated Resident A is non-verbal but uses a bliss

board to communicate and can communicate effectively using this device. Ms. Olson stated Resident A reported that Ms. Johnson put her ½ way into her bed, that she had her foot on the floor and Ms. Luttrull came and helped her. Ms. Olson reported that Resident A said Ms. Johnson made residents go to bed before they wanted to and that she (Resident A) had to hold herself up by placing her foot on the floor so she did not fall out of her bed. Ms. Olson reported that Resident A said she wanted to go to bed earlier but Ms. Johnson did not want to deal with putting her to bed.

On 04/03/2026, I interviewed Resident A, at day program with the assistance of the day program supervisor, Jamie Romanowsky. Resident A is nonverbal but uses a “bliss board” to communicate. Resident A stated, by using the bliss board, she could not remember being put to bed with ½ her body off the bed and stated “no” to her legs being left hanging off the bed. Resident A stated she has been left in dirty, wet briefs at the facility and staff have refused to put her bed when she wanted to go to bed. Resident A stated the staff was not Ms. Johnson but that it was Ms. McDowell.

On 04/06/2026, I interviewed Ms. Johnson via telephone. Ms. Johnson stated the information provided in the allegations are “all a lie” and that she never put Resident A to bed with her legs hanging off the side of the bed. Ms. Johnson stated she had not refused to allow Resident A to go to bed when she wanted to, left her in the hallway crying or that she left Resident A’s personal hygiene needs unattended.

On 04/13/2026, I conducted an exit conference with Anna Hinton via telephone. Ms. Hinton agreed with the information, analysis, and conclusion of this applicable rule.

| APPLICABLE RULE | |
|------------------------|---|
| R 400.681 | Resident rights; licensee responsibilities. |
| ANALYSIS: | (1) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe. |
| | The complainant reported that Getorra Johnson refused to put Resident A to bed. Resident A sat in the hallway for 2 hours crying and screaming and when Ms. Johnson put Resident A into bed, Resident A’s legs were hanging off the bed, and she was sliding to the floor. Based on staff and resident interviews, there is not a preponderance of evidence to indicate Resident A’s care needs were unattended to by DCW Getorra Johnson. A violation of this applicable rule is not established. |
| CONCLUSION: | VIOLATION NOT ESTABLISHED |

ALLEGATION: Resident A had open sores due to lack of care.

INVESTIGATION: On 02/23/2026, I received a LARA-BCHS (Licensing and Regulatory Affairs, Bureau of Community Health Systems) Online complaint. The complainant reported Resident A has sores on her bottom from not getting changed during 2nd shift.

On 02/26/2026, Licensing Consultant Natasha Grew and I conducted an unannounced inspection at the facility and interviewed Tracy Kroll, program manager. Ms. Kroll stated she showered Resident A on Monday, 02/23/2026 and she did not see any sores on Resident A.

On 02/26/2026, Ms. Grew and I interviewed DCW Damyea Wallace. Ms. Wallace stated she cared for Resident A often. Resident A refused showers, would yell and want to stay in bed but there have never been sores on her bottom or anywhere on her body.

On 02/26/2026, Ms. Grew and I requested to interview Resident A but Resident A moved out of the facility on 02/23/2026.

On 03/02/2026, I interviewed DCW Desiree Luttrull via telephone. Ms. Luttrull stated she had not seen sores on Resident while changing her.

On 03/06/2026, I interviewed DCW Ebony McDowell via telephone. Ms. McDowell stated this allegation is not true and Resident A did not have sores while at this facility.

On 04/03/2026, I interviewed Resident A, at day program with the assistance of the day program supervisor, Jamie Romanowsky. Resident A confirmed that she had sores on her bottom and did not see a doctor when she had the sore. The sore is healed now and she cannot remember when she had the sore.

On 04/03/2026, I interviewed Ms. Romanowsky and Lana Reyes, support staff at MOKA. They stated they provide care for Resident A while she is at day programming several days a week and have not seen any sores on Resident A's bottom.

On 04/06/2026, I interviewed Ms. Johnson via telephone. Ms. Johnson stated she did not see a sore on Resident A while she was a resident in this facility.

On 04/13/2026, I conducted an exit conference with Anna Hinton via telephone. Ms. Hinton agreed with the information, analysis, and conclusion of this applicable rule.

| APPLICABLE RULE | |
|------------------------|--|
| R 400.681 | Resident rights; licensee responsibilities. |

| | |
|--------------------|--|
| | (1) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe. |
| ANALYSIS: | <p>The complainant reported Resident A has sores on her bottom from not being changed during 2nd shift hours.</p> <p>Ms. Kroll, Ms. Wallace, Ms. Luttrull, Ms. McDowell, Ms. Romanowsky, Ms. Reyes and Ms. Johnson stated Resident A did not have any sores on her bottom while a resident in this facility.</p> <p>Resident A stated she had a sore that healed. She did not see a doctor about the sore and she cannot remember when she had the sore.</p> <p>There is not a preponderance of evidence to indicate Resident A had a sore due to lack of care by staff at the facility. Therefore, a violation of this applicable rule is not established.</p> |
| CONCLUSION: | VIOLATION NOT ESTABLISHED |

ALLEGATION: Resident A is not provided with snacks.

INVESTIGATION: On 02/23/2026, I received a LARA-BCHS (Licensing and Regulatory Affairs, Bureau of Community Health Systems) Online complaint. The complainant reported Resident A’s snacks must be prepared according to a pureed special diet and staff do not want to prepare snacks for her special diet, so Resident A goes without snacks.

On 02/26/2026, Licensing Consultant Natasha Grew and I conducted an unannounced inspection and interviewed DCW Damyea Wallace. Ms. Wallace stated Resident A got snacks, she refused snacks sometimes or she wanted a different type of snack and would use a picture board to relay to staff what she wanted for snack instead of what they were serving.

On 02/26/2026, Ms. Grew and I interviewed DCW Jeff Taylor and Mr. Taylor stated Resident A was given snacks after dinner at approximately 7:30-8:00p.m.

On 02/26/2026, Ms. Grew and I requested to interview Resident A but Resident A moved out of the facility on 02/23/2026.

On 02/26/2026, Ms. Grew and I interviewed Resident C in his room at the facility. Resident C stated residents are given a snack.

On 03/02/2026, I interviewed DCW Desiree Luttrull via telephone. Ms. Luttrull stated staff “might give (Resident A) a snack or they don’t.” Ms. Luttrull stated she was

working with DCW Ebony McDowell when Ms. McDowell said to Resident A, “you know how long it takes for your food to get ready, so, you have to wait.” Ms. Luttrull stated she ended up making Resident A’s snack which takes a bit longer to prepare because of her pureed special diet, but Resident A got the snack.

On 03/06/2026, I interviewed DCW Ebony McDowell via telephone. Ms. McDowell stated this allegation is untrue and that Resident A is given a snack, there are times when she goes to bed early, refuses a snack or wants something different than the snack being served, but snacks are offered and served to Resident A.

On 04/03/2026, I interviewed Resident A, at day program with the assistance of the day program supervisor, Jamie Romanowsky. Resident A stated she was not given snacks at this facility. When questioned more about snacks provided at the facility, Resident A stated she did not ask staff for more food or snacks because she did not want staff to get angry with her but then Resident A stated when she did ask for more food or snacks, some staff would refuse while others gave more food and snacks.

On 04/06/2026, I emailed Licensee Designee, Anna Hinton and requested Resident A’s weight records. Ms. Hinton stated they do not have any weight records that she is able to locate at the facility.

On 04/06/2026, I interviewed Ms. Johnson via telephone. Ms. Johnson stated Resident A was offered and given snacks, sometimes she wanted a snack while other times she did not. Ms. Johnson stated Resident A was provided with snacks while at this facility.

On 04/13/2026, I conducted an exit conference with Anna Hinton via telephone. Ms. Hinton agreed with the information, analysis, and conclusion of this applicable rule.

| APPLICABLE RULE | |
|------------------------|--|
| R 400.663 | Nutrition; adoption by reference. |
| | (3) Not more than 14 hours must elapse between the evening and morning meal. |
| ANALYSIS: | <p>The complainant reported that staff at the facility did not want to prepare snacks for Resident A’s special diet, so Resident A went without snacks.</p> <p>Ms. Wallace, Mr. Taylor, Resident C, Ms. McDowell and Ms. Johnson stated Resident A got snacks at the facility.</p> <p>Ms. Luttrull stated staff told Resident A she had to wait for a snack but Ms. Luttrull prepared the snack and gave it to Resident A.</p> |

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| | <p>Resident A stated she was not given snacks when she lived in this facility.</p> <p>There is not a preponderance of evidence to support that Resident A was denied snacks at this facility. A violation of this applicable rule is not established.</p> |
| CONCLUSION: | VIOLATION NOT ESTABLISHED |

ADDITIONAL FINDINGS

INVESTIGATION: On 04/03/2026, Ms. Romanowsky and Lana Reyes, support staff at MOKA stated they have seen noticeable weight loss while Resident A lived at this facility.

On 04/06/2026, I emailed Licensee Designee, Anna Hinton and requested Resident A’s weight records. Ms. Hinton stated they do not have any weight records that she is able to locate at the facility.

On 04/09/2026, I interviewed Kara Kile, Health West Supports Coordinator for Resident A via telephone. Ms. Kile stated Resident A is being monitored regularly by Dr. G. Devivo through Integrated Health Clinic. Ms. Kile stated Dr. Devivo charted visits to the clinic on ‘11/12/2025 with a weight of 103lbs and on 02/19/2026 a weight of 96lbs. The chart on 02/19/2026 noted a weight loss of 45 lbs. since April 2025, and the Dr. added that if the chart weight is to be believed, it is unlikely that (Resident A) has discreetly lost 1/3 of her body weight and documented that he does not know when an accurate body weight was last obtained.’ Ms. Kile confirmed that Resident A appeared to be seen on a regular basis by Dr. Devivo at Integrated Health Clinic.

On 04/10/2026, I interviewed Chloe Bayne, Integrated Health Clinic nurse and Suzanne Beckman, Health West nurse via telephone. Ms. Bayne stated the last weight on 02/19/2026, 96lbs. was obtained electronically by putting Resident A on the scale and the weight obtained on 11/12/2025, 103lbs. was reported by the person who brought Resident A to the appointment. Ms. Bayne stated in 2024 Resident A’s weight was documented as 148lbs and the weight of the wheelchair 65.6lbs. which would have made her weight approximately 82.4lbs. Ms. Bayne stated Resident A’s next appointment is 05/21/2026, they will get an accurate weight at that time and Ms. Bayne confirmed that Resident A is being seen on a regular basis at the clinic and her weight is being monitored by Dr. Devivo.

On 04/13/2026, I conducted an exit conference with Anna Hinton via telephone. 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 400.691(1) | Resident records. |
| | (1) A licensee shall complete and maintain a separate record for each resident that includes all of the following: (a) Personal information including all of the following: (g) Admission and monthly weight record. |
| ANALYSIS: | Upon request to review Resident A's weight records, the licensee designee, Anna Hinton stated they do not have weight records for Resident A. Therefore, a violation is established. |
| CONCLUSION: | VIOLATION ESTABLISHED |

IV. RECOMMENDATION

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



04/13/2026

Elizabeth Elliott
Licensing Consultant

Date

Approved By:



04/13/2026

Jerry Hendrick
Area Manager

Date