GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

May 21, 2026

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

RE: License #:	AS610419009
Investigation #:	2026A0356030
	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.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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 #:	AS610419009
Investigation #:	2026A0356030
Complaint Receipt Date:	03/23/2026
Investigation Initiation Date:	03/23/2026
Report Due Date:	05/22/2026
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?
Resident A and Resident B were not administered their medications as prescribed.	Yes
Resident B was not provided with medical treatment in a timely manner.	Yes
Additional Findings	Yes

III. METHODOLOGY

03/23/2026	Special Investigation Intake 2026A0356030
03/23/2026	APS Referral Stephanie Kindle, APS worker, DHHS.
03/23/2026	Special Investigation Initiated - Telephone Stephanie Kindle, APS.
03/30/2026	Contact - Telephone call made Jessica Sobers, RN, Health West.
03/31/2026	Contact - Telephone call made Melissa Wynsma, NP
04/03/2026	Contact-Telephone call received Sarah Wilson, RN, Health West
04/03/2026	Contact-Document received Sarah Wilson, RN, Health West
04/06/2026	Contact - Document Sent Anna Hinton-LD, email.
04/07/2026	Contact - Telephone call made Anna Hinton, Licensee Designee.
04/07/2026	Contact - Telephone call made Casey Olson, HW, ORR
04/07/2026	Contact - Telephone call made Anna Hinton, LD.

04/07/2026	Contact-Document received IR, facility documents.
04/30/2026	Inspection Completed On-site
04/30/2026	Contact - Face to Face DCW Jeff Taylor, DCW Latoya Logan.
04/30/2026	Contact - Face to Face Resident A, Resident B
04/30/2026	Contact - Document Received MARs reviewed.
05/21/2026	Exit conference-Anna Hinton, Licensee Designee.

ALLEGATION: Resident A and Resident B were not administered their medications as prescribed.

INVESTIGATION: On 03/23/2026, I received a LARA-BCHS (Licensing and Regulatory Affairs, Bureau of Community Health Systems) online complaint. The complainant reported that Resident A's urine drug screen showed Ativan in his system, but Resident A is not prescribed Ativan. The complainant reported on 03/07/2026, Resident A had a seizure and Ativan can cause seizures. Resident A was not known to have seizures prior to taking Ativan. In addition, the AFC home reported they mistakenly gave Resident A another resident's medication. Muskegon County Department of Health and Human Services (DHHS) Adult Protective Services worker Stephanie Kindle has an open investigation.

On 03/30/2026, I interviewed Jessica Sobers, RN (Registered Nurse) Health West via telephone. Ms. Sobers stated Resident A's primary care physician is Melissa Wynsma, NP (Nurse Practitioner) at Trinity Health. Ms. Sobers stated Resident A was recently hospitalized for bilirubin issues and Valium (Diazepam) should be administered prior to wound care but not Ativan (Lorazepam). Ms. Sobers stated Ativan had not been prescribed to Resident A and should not show up in a urine drug screen.

On 03/31/2026, I interviewed Dr. Wynsma, Trinity Health NP via telephone. Dr. Wynsma stated she prescribed Resident A Valium to be taken prior to wound care appointments but during a routine urine drug screening on 03/06/2026, the medication Ativan showed as positive. Dr. Wynsma stated she had not prescribed Ativan to Resident A and it should not be showing up in his system. Dr. Wynsma stated on 03/07/2026, Resident A went to ER (emergency room) with a breakthrough seizure. Dr. Wynsma stated that a withdrawal from diazepines, which Ativan is one, can cause seizures.

Dr. Wynsma stated on 03/09/2026, she received a telephone call from Anna Hinton, Licensee Designee, who reported that Resident A had been given 10mg of Baclofen (not Ativan), which was another resident's medication and not prescribed to Resident A but that Resident A never received Ativan while in the facility. Dr. Wynsma stated no one from the facility reported to her that Resident A been given Ativan, but she "assumed" Resident A was given another resident's Ativan because she did not prescribe Ativan to Resident A and it showed up in his system. Dr. Wynsma stated Resident A getting a dose of Resident B's Baclofen is a different medication issue. Dr. Wynsma stated she conducted a review of the MAPS (Michigan Automated Prescription System), and it does not show a prescription for Ativan for Resident A from any other doctor.

Dr. Wynsma stated Resident A was hospitalized for low hemoglobin, severe anemia and a pressure ulcer on his sacrum from 01/27/2026-02/17/2026 and it is possible he was given Ativan while in the hospital. Dr. Wynsma stated even then, the medication would not show up in a drug screen three weeks after discharge from the hospital.

Dr. Wynsma stated on 03/30/2026, she received a telephone call from Ms. Hinton who reported that she (Ms. Hinton) called the cancer and hematology center on 03/30/2026 and asked if Resident A had received Ativan while at the infusion appointment on 03/04/2026. Ms. Hinton stated she was told yes, each time Resident A gets an infusion, Resident A is given a dose of Ativan.

On 04/03/2026, I received a telephone call from Sarah Wilson, Health West RN and a follow-up email adding another medication administration issue to this complaint. Ms. Wilson email stated, *'Yesterday, 04/02/2026, (Resident B) was given her 2p.m. dose of Baclofen twice within an hour. Once by day shift and once by 2nd shift. I talked with Anna about it yesterday and told her to hold the 8p.m. dose. This morning, she called to tell me that the 8p.m. worker still gave the dose even though she had told her not to.'*

On 04/06/2026, I interviewed DCW (direct care worker) Getorra Johnson via telephone regarding Resident A possibly being given Ativan in error by staff at the facility. Ms. Johnson stated none of the home's residents get Ativan and she did not know how Resident A would have Ativan in his system.

On 04/07/2026, I interviewed Casey Olson, Health West, Office of Recipient Rights. Ms. Olson stated she interviewed Angela Pouch, Health West RN. Ms. Olson reported that Resident A is prescribed Ativan for the Infusion, Cancer and Hematology Center. Ms. Olson stated Ms. Pouch reported that Ativan could be in his system from those procedures. Ms. Olson stated, however, Baclofen was not supposed to be given to Resident A.

On 04/07/2026, I interviewed Ms. Hinton via telephone regarding Resident B's Baclofen medication being administered to Resident A. Ms. Hinton stated Resident

A was given ½ tab of Resident B's Baclofen and confirmed that Baclofen is not a medication prescribed to Resident A.

On 04/07/2026, I interviewed Ms. Hinton via telephone regarding Ativan in Resident A's system as reported by Dr. Wynsma. Ms. Hinton stated Resident A went to the cancer and hematology center on 03/04/2026 and was given Ativan there and then on 03/06/2026, he got a blood draw from Dr. Wynsma at Trinity Health and the Ativan showed up in his system. Ms. Hinton stated none of the home's residents are prescribed Ativan and upon being notified that Ativan was present in Resident A's drug screen, she reviewed the Medication Administration Records (MARs) and medications in the facility and did not find any Ativan.

On 04/07/2026, I interviewed Ms. Hinton via telephone. Ms. Hinton stated that on 04/02/2026, at 2:00p.m. shift change, Resident B was given double the 2:00p.m. medication Baclofen. Ms. Hinton stated Ms. Wilson RN told her to hold the 8:00p.m. administration and she told DCW Anaya Brown to hold the 8:00p.m. medication, but Ms. Brown administered the 8:00p.m. medication anyway. Ms. Hinton stated Ms. Brown had worked 1st shift with Ebony McDowell and Ms. Brown left the facility to run an errand and Ms. McDowell administered the 2:00p.m. Baclofen to Resident B, then Ms. Brown came back to the facility, did not look at the MAR first, and gave the medication to Resident B a second time. Then the 8:00p.m. Baclofen was administered as prescribed when it should have been held due to the double dose earlier in the day. Ms. Hinton acknowledged that medication error happened.

On 04/07/2026, I reviewed an IR (Incident Report) dated 03/27/2026, written by Anna Hinton, Licensee Designee. The IR documented the following information, *'Dr. Wynsma had Anaya Brown (DCW) call this writer during (Resident A's) appointment (10:45a.m., follow up after 03/07/2026 ER visit due to seizure), and provide the following information, #1). On 03/06/2026 "Ativan" was found in a urine sample. #2). Seizure: if (Resident A) had been routinely receiving Ativan and then stopped taking it, the seizure could have been due to "withdrawal." #3). On 03/09/2026, (Resident A) was administered Baclofen belonging to another resident.'* The IR documented*: Action taken by staff: 'Ativan: (Resident A) does not have a prescription for Ativan. I checked housemates MARs and did not find a prescription for Ativan. I then went through the entire med cart and med cabinets and did not find any Ativan. Baclofen: On 03/09/2026, (Resident A) was mistakenly administered "Baclofen Tab 20 mg, ½ tablet" meant for a different resident. The mistake was immediately noticed, and the staff person notified this writer, left a message for the RN and wrote an incident report. This writer spoke with the RN and was told what to watch out for and to take him to the ER if he began exhibiting symptoms. The case manager and RN were notified of this conversation with Dr. Wynsma*.'

On 04/30/2026, I conducted an unannounced inspection at the facility and interviewed DCW's Jeff Taylor and LaToya Logan. Mr. Taylor and Ms. Logan stated none of the residents are prescribed Ativan and to their knowledge, there is no Ativan medication in the facility.

On 04/30/2026, I conducted an unannounced inspection at the facility and reviewed Resident A, B, C, D and E's MARs. None of the residents' MARs include Ativan (Lorazepam) as a medication prescribed for any of the residents in the home.

On 04/30/2026, I reviewed Resident A's MAR and Resident A does not have Baclofen documented as a prescribed medication. I reviewed Resident B's MAR and Resident B is prescribed Baclofen Tab 20mg, take ½ tablet by mouth three times daily. Resident B's MAR for the month of April 2026 documents Baclofen Tab 20 mg take ½ tablet by mouth three times daily is prescribed. On 04/02/2026, the medication is documented as administered at 8:30a.m. by Ms. Brown, at 2:00p.m., by Ms. McDowell and at 8:30p.m. by Ms. Brown. The 2:00p.m. is reportedly when the double dose occurred, however, the MAR is only signed by one of the DCW's.

On 05/11/2026, I interviewed Angela Pouch, Health West RN. Ms. Pouch confirmed that Resident A was not prescribed Ativan and none of the residents in the home were prescribed Ativan but that the medication had been given to Resident A at a medical appointment at the cancer and hematology infusion center. Ms. Pouch stated she does not know why the Ativan given to Resident A at the infusion center did not show up on the MAPS system.

Ms. Pouch confirmed that Resident A was given one dose of Baclofen by staff at the home, and that the Baclofen is prescribed to Resident B and not to Resident A. Ms. Pouch stated she discussed this incident with Ms. Hinton and requested that she follow-up with Resident A's primary care physician, which Ms. Hinton did and was provided guidance and care instructions.

On 05/11/2026, I interviewed Kara Kile, Health West case manager for Resident A. Ms. Kile confirmed that Resident A was given Ativan at an infusion clinic. Ms. Kile also confirmed that Resident A was given a dose of Resident B's Baclofen by staff.

On 05/21/2026, I conducted an exit conference with Anna Hinton, Licensee Designee. Ms. Hinton stated she is checking in with staff every shift to review the residents' medications and to review with staff that the administration of the medications is accurate. Ms. Hinton stated things are going well and she will continue to do this. Ms. Hinton stated she understands the information, analysis, and conclusion of this applicable rule.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.
ANALYSIS:	The complainant reported that Resident A's urine drug screen showed Ativan in his system, but Resident A is not prescribed

	Ativan. The complainant also reported that the AFC home staff mistakenly gave Resident A, Resident B's medication. Based on my investigative findings it was confirmed that Ativan is not prescribed to Resident A or to any other resident in the home. The Ativan detected in Resident A's system is administered to him at the cancer and hematology infusion appointments Resident A attends and not by home staff. However, on 03/09/2026, Resident B's Baclofen medication was administered to Resident A erroneously by staff at the facility. In addition, on 04/02/2026, Resident B was given Baclofen twice at the 2:00p.m. administration time. Ms. Wilson, RN instructed staff to hold the 8:30p.m. dose of Baclofen but the medication was administered to Resident B despite Ms. Wilson's instructions. Therefore, a violation of this applicable rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident B was not provided with medical treatment in a timely manner.

INVESTIGATION: On 04/03/2026, I received a telephone call from Sarah Wilson, Health West RN (Registered Nurse) with a follow-up email containing the following complaint information. Ms. Wilson stated, *'The home staff, Ebony (McDowell) reached out to me 3 times in the past week because (Resident B) had been sick (probably a cold). On 03/23/2026, she (Ms. Wilson) directed Ms. McDowell to call (Resident B's) doctor (which she said she did) then she followed up with me on 03/25/2026 that (Resident B) was still sick so I told her that if she can't get a hold of the primary care to take the client into urgent care. I found out Monday, 03/30/2026, that the client still had not been to urgent care and they have not called the doctor back and the client is still sick. Per Ebony, Anna (Hinton) is the one who told her not to take the client in and not to follow up with her PCP. I reached out to Anna, and she said that (Resident B) seemed better, so she did not feel the need to have her be seen. I asked her to call (Resident B's) primary care and check with them since she was still sick. Anna called me back and said primary care said to monitor her but since she seemed better, they did not need to see her. Then today, 04/03/2026, Amy, the Health West case worker was out there and said that her (Resident B's) eyes were still goopy and she was wheezy. I called Anna and told her to follow up with her PCP. Then this afternoon, I called her and she had not called the PCP, so I told her that (Resident B) needed to go to urgent care.'*

Ms. Wilson stated Resident B was finally seen at urgent care on 4/3/26 and diagnosed with Acute non-recurrent pansinusitis (infection of all paranasal sinus cavities), Acute conjunctivitis of both eyes, unspecified acute conjunctivitis type (pink eye) and wheezing.

On 04/07/2026, I interviewed Ms. Hinton via telephone. Ms. Hinton acknowledged that everything documented in Ms. Wilson's email did occur as stated. Ms. Hinton stated Ms. McDowell told her that Ms. Wilson instructed her to take Resident B to urgent care on 03/25/2026 but they did not take Resident B in until 04/03/2026.

On 05/21/2026, I conducted an exit conference with Anna Hinton, Licensee Designee. Ms. Hinton again acknowledged that this incident occurred and accepted responsibility for the error. Ms. Hinton stated she understood the information, analysis, and conclusion of this applicable rule.

APPLICABLE RULE	
R 400.689	**Resident health care.**
	(3) In case of an accident or sudden adverse change in a resident's health condition, a facility shall obtain needed health care immediately.
ANALYSIS:	Ms. Wilson, RN reported she instructed Ms. McDowell to take Resident B to urgent care on 03/25/2026 if a doctor consult was not completed. Resident B was not seen by a doctor until 04/03/2026. Ms. Hinton acknowledged that this information is accurate and therefore, a violation of this applicable rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDING

INVESTIGATION: On 04/30/2026, I reviewed Resident A and B's MARs for the month of April 2026. Resident A's MAR showed the following medications were not signed as administered by staff:

- Diclofenac gel 1%, apply 2 grams topically three times daily to both knees and shoulders, 8:30a.m., 12:00p.m., 8:30p.m. Not signed as administered at all, at any of the times documented from 04/01/2026-04/30/2026.
- Docusate Sodium 100mg caps, MMI, take one capsule by mouth twice daily, 8:30a.m., 8:30p.m. on 04/16/2026.
- Ensure Max Liq, drink 1 can by mouth twice daily, 8:30a.m., 8:30p.m., not signed as administered at 8:30a.m. at all, from 04/01/2026-04/30/2026. At 8:30p.m., not signed as administered on 04/03, 04/04/, 04/05, 04/06, 04/07, 04/08, 04/09, 04/26, and 04/29/2026.

- Ferrous Sulfate 325 mg TBEC MMI, take one tablet by mouth every other day. The medication is administered at 8:30a.m. and on 04/16/2026, it is not signed as administered by staff.
- Fexofenadine 180MG MMI, take one tablet by mouth once daily, 8:30a.m. is not signed as administered on 04/16 and 04/19/2026.
- Furosemide Tab 40MG, take one tablet by mouth once daily at 8:30a.m. not signed as administered on 04/16 and 04/19/2026.
- Ipratropium/SOL Albuterol, inhale contents of 1 vial via nebulizer once daily at 8:30a.m., no signed as administered on 04/07, 04/09, 04/10, 04/11, 04/12, 04/13, 04/15, 04/16/2026.
- Lacosamide tab 100mg, take one tablet (100mg) by mouth twice daily *max daily amount 200mg, 8:30a.m., and 12:00p.m. not signed as administered on 04/16/2026.
- Lamotrigine Tab 100mg, take one tablet by mouth at noon, 12:00p.m., not signed as administered on 04/16 and 04/19/2026.
- Montelukast tab 10mg, take one tablet by mouth once daily at 8:30a.m. is not signed as administered on 04/16/2026.
- Mupirocin Ointment 2%, apply to left lower leg wound three times weekly at dressing change, 8:30a.m. is not signed as administered on 04/06, 04/08, 04/10, and 04/13/2026.
- Oxybutynin tab 5mg, take one tablet by mouth twice daily, 8:30a.m. and 8:30p.m. is not signed as administered on 04/16/2026.
- Pregabalin cap 50mg, take one capsule by mouth twice daily, max daily amount 100mg, 8:30a.m. and 8:30p.m. is not signed as administered on 04/16/2026.
- Tab-A-Vite tab Iron/BET, take one tablet by mouth once daily, 8:30a.m. is not signed as administered on 04/16/2026.
- Trazadone tab 50mg, take one tablet by mouth at noon, 12:00p.m. is not signed as administered on 04/16/2026.
- Ventolin HFA AER, inhale two puffs by mouth twice daily at 8:30a.m. and 8:30p.m. not signed as administered on 04/10/2026, 8:30a.m. and 8:30p.m., on 04/13/2026 at 8:30p.m., 04/16/2026 at 8:30a.m., 04/28/2026 at 8:30a.m.
- Mupirocin Ointment 2% apply topically three times a day for 10 days (to right arm) 8:00a.m., 4:00p.m. and 8:00p.m. is not signed as administered on 04/16/2026 at 8:00a.m.
- Atovaquone SUS 750/5ml take 10ml (1500mg) once daily while on steroid taper, 8:00a.m. not signed as administered on 04/16/2026.
- Prednisone tab 10mg take three (3) tablets once daily by mouth for 7 days, 8:00a.m. is not signed as administered on 04/16/2026.

Resident B’s MAR showed the following medications were not signed as administered by staff:

- Baclofen tab 20mg take ½ tablet by mouth three times daily, 8:30a.m., 2:00p.m., 8:30p.m., is not documented as administered on 04/28/2026, 2:00p.m.
- Boost liquid chocolate, drink 1 can twice daily, 8:30a.m. and 8:30p.m. is not documented as administered on 04/07 at 8:30p.m., 04/08 at 8:30a.m. and 04/14/2026 at 8:30a.m.
- Polyeth Glyc Pow 3350, mix contents of 1 packet (17 ounces) in 8 ounces of water or liquid and drink once daily "off cycle request when needed" 8:30a.m. is not signed as administered on 04/10/2026.

On 05/21/2026, I conducted an exit conference with Anna Hinton, Licensee Designee. Ms. Hinton stated she is checking in with staff every shift to review the residents' medications and to review with staff that the documentation of the medications is complete. Ms. Hinton stated she understood the information, analysis, and conclusion of this applicable rule.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(4) A licensee, administrator, or direct care staff shall comply with the following when supervising the taking of medication by a resident: (b) Complete an individual medication log that contains all of the following: (v) Initials of the individual who administered the medication at the time given.
ANALYSIS:	Resident A and B's medications were not signed as administered according to licensing requirements. This is a repeat violation from the Renewal Inspection dated 09/16/2025, which cited R 400.14312 (1) for failure to document resident medications as administered on the MAR. I received a Corrective Action Plan on 10/03/2025 written by Licensee Designee, Anna Hinton documenting the measures taken to correct the medication documentation errors.
CONCLUSION:	**VIOLATION ESTABLISHED**

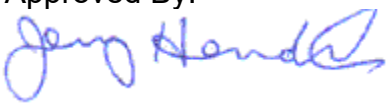
IV. RECOMMENDATION

On 09/16/2025, I cited R 400.675 (b) (v) during a renewal inspection due to violations pertaining to resident medications. Due to the repeat and additional quality of care violations, I recommend the license is modified to a 6-month provisional license status.

05/21/2026

Elizabeth Elliott Date
Licensing Consultant

Approved By:



05/21/2026

Jerry Hendrick Date
Area Manager