GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

August 16, 2022

Gordon Plescher and Tammy Plescher
3492 Main St.
Ravenna, MI 49451

RE: License #: AF610391199
Investigation #: 2022A0583040
Tibbet House Elder Care Home

Dear Gordon Plescher and Tammy Plescher:

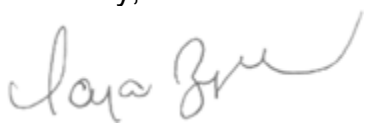
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0183.

Sincerely,



Toya Zylstra, Licensing Consultant
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
(616) 333-9702

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AF610391199
Investigation #:	2022A0583040
Complaint Receipt Date:	07/29/2022
Investigation Initiation Date:	08/01/2022
Report Due Date:	08/28/2022
Licensee Name:	Gordon Plescher and Tammy Plescher
Licensee Address:	3492 Main St. Ravenna, MI 49451
Licensee Telephone #:	(616) 675-4241
Administrator:	N/A
Licensee Designee:	N/A
Name of Facility:	Tibbet House Elder Care Home
Facility Address:	3492 Main St. Ravenna, MI 49451
Facility Telephone #:	(616) 675-4241
Original Issuance Date:	01/31/2018
License Status:	REGULAR
Effective Date:	07/31/2020
Expiration Date:	07/30/2022
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Licensees Gordon and Tammy Plescher terminated Resident A's hospice services.	Yes
On two occasions, licensees Gordon and Tammy Plescher did not notify Resident A's legal decision maker and next of kin of Resident A's hospitalizations.	Yes
Licensee Tammy Plescher did not administer Resident A's Morphine as prescribed.	Yes
Licensee Gordon Plescher was made trustee of Resident A's trust.	Yes

III. METHODOLOGY

07/29/2022	Special Investigation Intake 2022A0583040
08/01/2022	Special Investigation Initiated - Telephone Relative 1
08/02/2022	Contact - Telephone call made Public Guardian Jan Waterway
08/02/2022	Contact - Telephone call made Relative 1
08/03/2022	Inspection Completed On-site Licensee Gordon Plescher
08/03/2022	Contact - Telephone call received Licensee Tammy Plescher
08/03/2022	Contact - Document Received Relative 1
08/10/2022	Contact - Telephone call made Licensee Gordon Plescher
08/10/2020	Contact - Document Received Licensee Gordon Plescher
08/10/2022	Contact - Telephone call made Melissa Schmidt, Emmanuel hospice director of clinical services
08/16/2022	Exit Conference Licensee Gordon Plescher

ALLEGATION: Licensees Gordon and Tammy Plescher terminated Resident A's hospice services.

INVESTIGATION: On 07/29/2022 complaint allegations were received from the BCAL online reporting system. The complaint allegations were assigned to me for investigation on 08/02/2022. The complaint included an allegation that licensees Gordon and Tammy Plescher terminated Resident A's hospice services against the direction of Resident A's legal decision maker and son (Relative 1).

On 08/02/2022 I interviewed Public Guardian Jan Waterway via telephone. Ms. Waterway stated Resident A was admitted to the facility in December 2019 and at that time Resident A's only living child, Relative 1, was her legal decision maker via an activated Power of Attorney for finances and medical. Ms. Waterway stated at the time of admission Resident A suffered from dementia and declared unable to make her own decisions. Ms. Waterway stated in July 2020 a referral for hospice services was made and shortly thereafter licensees Gordon and Tammy Plescher refused to allow hospice service providers to continue. Ms. Waterway stated in August 2020 licensees Gordon and Tammy Plescher assisted Resident A with removing Relative 1 as her legal decision maker and replaced Mr. Plescher as Trustee over finances and Mrs. Plescher as Medical Patient Advocate. Ms. Waterway stated hospice services initiated a petition to the Ottawa Probate court to appoint Resident A a legal guardian and Ms. Waterway was subsequently appointed as such in August 2020. Ms. Waterway stated Resident A was hospitalized and died soon after Ms. Waterway was appointed legal guardian.

On 08/02/2022 I interviewed Relative 1 via telephone. Relative 1 stated Resident A moved into the facility December 2019 and at that time was suffering from memory decline. Relative 1 stated on 01/06/2020 Resident A was declared by two physicians, Dr. Spoolstra (Primary Care Physician) and Dr. Reckow (Neurologist) unable to make her own decisions thereby enacting Relative 1's Power of Attorney over medical and finances. Relative 1 stated Resident A's Primary Care Physician completed a referral for Emmanuel hospice for Resident A in July 2020 and licensees Gordon and Tammy Plescher refused to allow the service into the facility after a handful of appointments. Relative 1 stated on 08/13/2020 Mr. and Mrs. Plescher assisted Resident A with securing a new attorney and drafted a new declaration asserting Mr. Plescher as trustee of finances and Mrs. Plescher as Medical Patient Advocate. Relative 1 stated in August 2020, Emmanuel hospice services filed a petition with the Ottawa County Probate Court requesting a public guardian be appointed for Resident A and subsequently Jan Waterway was appointed as such. Relative 1 stated Resident A was hospitalized and died shortly after Ms. Waterway's appointment.

On 08/03/2022 I completed an unannounced onsite investigation at the facility and interviewed licensee Gordon Plescher. Mr. Plescher stated that upon Resident A's admittance to the facility December 2019, Resident A's son was activated as her Power of Attorney due to Resident A's memory loss. Mr. Plescher stated around

July 2020 Resident A was referred to Emmanuel hospice services. Mr. Plescher stated after two visits Resident A reported she did not want Emmanuel hospice involved. Mr. Plescher stated that due to Resident A's refusal to work with Emmanuel hospice services, Mr. Plescher terminated the service. Mr. Plescher stated on 08/13/2020 he and his wife, licensee Tammy Plescher, assisted Resident A with securing a new attorney and subsequently drafted a new declaration asserting Mr. Plescher as trustee of finances and Mrs. Plescher as Medical Patient Advocate. Mr. Plescher stated in August 2020, Emmanuel hospice services filed a petition with the Ottawa County Probate Court requesting a public guardian be appointed for Resident A and subsequently Jan Waterway was appointed as such. Mr. Plescher stated Resident A was hospitalized and died shortly after Ms. Waterway's appointment.

On 08/03/2022 I interviewed licensee Tammy Plescher via telephone. Ms. Plescher stated in December 2019 Resident A was admitted to the facility with her son, Relative 1, as Resident A's activated Power of Attorney due to Resident A's memory loss. Ms. Plescher stated Emmanuel hospice services provided Resident A with in-home services "two to three times per week" or approximately "four to five weeks". Ms. Plescher stated she and licensee Gordon Plescher terminated Emmanuel hospice services because the service providers "upset" Resident A. Ms. Plescher stated that at the time of Emmanuel hospice's termination in August 2020, Ms. Plescher had already been appointed by Resident A as her Medical Patient Advocate and Mr. Plescher was appointed as Resident A's trustee of finances. Ms. Plescher stated Relative 1 argued that Mr. and Mrs. Plescher' s appointments in August 2020 were not legitimate and Emmanuel hospice filed a petition with the Probate court requesting a public guardian for Resident A which was granted August 2020 and Jan Waterway was appointed as such.

On 08/03/2022 I received and reviewed an email from Relative 1 which contained four separate documents. The first attached document is entitled "Lemmon letter". The document is dated 08/13/2022 and drafted by Attorney Larry A. Lemmon. The document revoked previous agents and instated licensee Gordon Plescher as co-trustee with Resident A over the Frank D. and Resident A Revocable Living Trust Agreement. The document also appointed licensee Tammy Plescher as Resident A's Patient Advocate. The second attached document was entitled "Mercy Health Reckow letter". The document was drafted by Dr. Jaclyn Reckrow PhD. of Mercy Health on 01/02/2022 with a signature of 01/03/2022. The document stated Resident A was diagnosed with unspecified dementia without behavioral disturbance. The document states Resident A does not have the capacity to understand her medical and cognitive status and states Dr. Reckrow recommended the activation of Resident A's Durable Power of Attorney for healthcare and finances. The third attached document is entitled "DHHS Beckman letter". The document was drafted by Adult Protective Services staff Ken Beckman and states Relative 1 was "acting within the scope of" his Power of Attorney in relation to Resident A. The third attached document is entitled "Mercy Health Spoolstra letter". The letter is drafted 01/06/2022 by Dr. Spoolstra, MD and states Resident A's

“memory is worsening” to the point she was “not able to make health and finance decisions”. The document stated that Resident A’s “DPOA” should “take over”.

On 08/10/2022 I interviewed Melissa Schmidt, director of clinical services for Emmanuel hospice. Ms. Schmidt stated Emmanuel hospice received a referral for end of life services for Resident A from St. Mary’s hospital and officially opened a case on 07/26/2020. Ms. Schmidt stated the case was opened for services from 07/26/2020 until October 2020. Ms. Schmidt stated at the initiation of hospice services Resident A’s son, Relative 1, was the enacted Power of Attorney. Ms. Schmidt stated that “mid to end of August 2020” licensees Gordon and Tammy Plescher stopped hospice from coming into the home and purported to be Resident A's legal decision makers. Ms. Schmidt stated Mr. and Mrs. Plescher were “not authorized to stop” hospice services given the fact that Relative 1 was the legal Power of Attorney. Ms. Schmidt stated Emmanuel hospice filed a petition with the Probate court, and public guardian Jan Waterway was appointed the end of August 2020 due to the discord between Relative 1 and Mr. and Mrs. Plescher. Ms. Schmidt stated Ms. Waterway continued Emmanuel hospice services briefly until transferring Resident A into a residential hospice facility.

On 08/16/2022 I completed an Exit Conference via telephone with Licensee Gordon Plescher. Mr. Plescher stated he does not agree with the finding but will submit a Corrective Action Plan.

APPLICABLE RULE	
R 400.1416	**Resident health care.**
	(1) A licensee, in conjunction with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician with regard to such items as medications, special diets, and other resident health care needs that can be provided in the home.
ANALYSIS:	Melissa Schmidt, director of clinical services for Emmanuel hospice, stated Emmanuel hospice received a referral for end of life services for Resident A from St. Mary’s hospital and officially opened a case on 07/26/2020. Ms. Schmidt stated at the initiation of hospice services Resident A’s son, Relative 1, was the enacted Power of Attorney. Ms. Schmidt stated that “mid to end of August 2020” licensees Gordon and Tammy Plescher “stopped” hospice personnel from coming into the home and purported to be Resident A’s legal decision makers. Ms. Schmidt stated Mr. and Mrs. Plescher were “not authorized to stop” hospice services given the fact that Relative 1 was the legal Power of Attorney

	A preponderance of evidence was discovered during the Special Investigation to substantiate a violation of the applicable rule. Licensees Gordon and Tammy Plescher prohibited hospice services from providing care.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: On two occasions, licensees Gordon and Tammy Plescher did not notify Resident A's legal decision maker and next of kin of Resident A's hospitalizations.

INVESTIGATION: On 07/29/2022 complaint allegations were received from the BCAL online reporting system. The complaint allegations were assigned to me for investigation on 08/02/2022. The complaint alleged that licensees Gordon and Tammy Plescher did not notify Resident A's son, Relative 1, of two hospitalizations.

On 08/02/2022 I interviewed Relative 1 via telephone. Relative 1 stated on two occasions licensees Gordon and Tammy Plescher did not notify him of Resident A's hospitalizations either verbally or in writing. Relative 1 stated on 07/17/2020 Resident A was hospitalized after a gastroenterology appointment and Relative 1 was not notified by licensees Gordon and/or Tammy Plescher. Relative 1 stated he was notified of the hospitalization the following Monday "by doctors". Relative 1 stated on 08/13/2020 Resident A was hospitalized due to "swollen feet". Relative 1 stated he was later notified by "lawyers" of the hospitalization. Relative 1 stated Mr. and Mrs. Plescher did not notify Relative 1 of the hospitalization because Mr. and Mrs. Plescher believed themselves to be Resident A's legal decision maker at that time.

On 08/03/2022 I completed an unannounced onsite investigation at the facility and interviewed licensee Gordon Plescher. Mr. Plescher stated Resident A was hospitalized on 07/17/2020 due to "breathing difficulty". Mr. Plescher acknowledged that he "didn't think" he notified Relative 1 of the hospitalization. Mr. Plescher stated he "thinks" licensee Tammy Plescher notified Relative 1 verbally. Mr. Plescher stated on 08/13/2020 Relative 1 was again hospitalized. Mr. Plescher stated he did not notify Relative 1 of the hospitalization and had "no idea" if Mrs. Plescher did so.

On 08/03/2022 I interviewed licensee Tammy Plescher via telephone. Ms. Plescher stated Resident A was hospitalized on or about 07/17/2020 and Mrs. Plescher "doesn't remember" if she notified Relative 1. Mrs. Plescher stated Relative 1 "was in contact with the hospital" and hospital staff notified Relative 1 of the hospitalization. Mrs. Plescher stated on 08/13/2020 Resident A was hospitalized. Mrs. Plescher stated she was not required to notify Relative 1 of the hospitalization because at that time "he lost his rights" to be Resident A's Power of Attorney and had been replaced by Mrs. Plescher.

On 08/16/2022 I completed an Exit Conference via telephone with Licensee Gordon Plescher. Mr. Plescher stated he does not agree with the finding but will submit a Corrective Action Plan.

APPLICABLE RULE	
R 400.1416	**Resident health care.**
	(4) A licensee shall make a reasonable attempt to contact the resident's next of kin, designated representative, and responsible agency by telephone, followed by a written report to the resident's designated representative and responsible agency within 48 hours of any of the following: (b) Any accident or illness requiring hospitalization.
ANALYSIS:	On 07/17/2020 and 08/13/2020, Resident A was hospitalized. Relative 1 stated he was not notified. Licensees Gordon Plescher and Tammy Plescher acknowledged they do not remember notifying Relative 1 of either hospitalization. A preponderance of evidence was discovered during the Special Investigation to substantiate violation of the applicable rule. Relative 1, who was Resident A's designated representative and next of kin was not notified of Resident A's two hospitalizations.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Licensee Tammy Plescher did not administer Resident A's Morphine as prescribed.

INVESTIGATION: On 07/29/2022 complaint allegations were received from the BCAL online reporting system. The complaint allegations were assigned to me for investigation on 08/02/2022. One of the allegations was that licensees Gordon and Tammy Plescher did not administer Resident A's Morphine as prescribed.

On 08/02/2022 I interviewed Relative 1 via telephone. Relative 1 stated Resident A was prescribed Morphine while under the care of Emmanuel hospice services in July and August 2020. Relative 1 stated licensee Tammy Plescher refused to administer Resident A's Morphine because Ms. Plescher reported that it made Resident A "goofy".

On 08/03/2022 I completed an unannounced onsite investigation at the facility and interviewed licensee Gordon Plescher. Mr. Plescher stated Resident A was prescribed Morphine as needed for pain while under the care of Emmanuel hospice. Mr. Plescher stated Resident A wasn't in pain therefore the medication was not administered.

On 08/03/2022 I interviewed licensee Tammy Plescher via telephone. Ms. Plescher stated Resident A was prescribed Morphine as needed for pain while under the care of Emmanuel hospice. Ms. Plescher stated she administered Resident A's Morphine as needed for pain, however Resident A was not in pain, therefore it was not administered regularly.

On 08/10/2022 I received an email from licensee Gordon Plescher with an attached document. The document was entitled "hospice medications" and was dated 09/10/2020 to 09/24/2020. The document was drafted by Emmanuel Hospice Services and stated that as of 08/11/2022 Resident A was prescribed Morphine 20 mg/ml once a day at bedtime and PRN once a day.

On 08/10/2022 I received an email from licensee Gordon Plescher with an attached document. The document was entitled "Med records" and consisted of Resident A's Medication Administration Records for July 2020, August 2020, and September 2020. The document indicated Resident A was prescribed Morphine .25 mg July 2020 "every 3 hours PRN for pain". The July 2020 Medication Administration Record indicated Resident A was administered Morphine .25 mg by licensee Tammy Plescher on 07/28/2020 and 07/30/2020 at 08:00 PM. The documentation indicated Resident A was prescribed Morphine .25 mg August 2020 "as needed for pain". The August 2020 Medication Administration Record indicated Resident A was administered Morphine .25 mg by licensee Tammy Plescher on 08/02/2020 and 08/04/2020 at 08:00 PM. The September 2020 Medication Administration Record does not indicate that Resident A was prescribed or administered Morphine.

On 08/10/2022 I interviewed Melissa Schmidt, director of clinical services for Emmanuel hospice. Ms. Schmidt stated Resident A was prescribed Morphine for pain, PRN in July 2020. Ms. Schmidt stated that on 08/11/2020 Resident A was prescribed Morphine 20 mg/ml once a day at bedtime and PRN once a day.

On 08/16/2022 I completed an Exit Conference via telephone with Licensee Gordon Plescher. Mr. Plescher stated he does not agree with the finding but will submit a Corrective Action Plan.

APPLICABLE RULE	
R 400.1418	**Resident medications.**
	(1) Prescription medication, including tranquilizers, sedatives, dietary supplements, or individual special medical procedures, shall be given or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy container which shall be labeled for the specific resident in accordance with the requirements of Act No. 368 of the

	Public Acts of 1978, as amended, being (33.1101 et. seq. of the Michigan Compiled Laws.
ANALYSIS:	Melissa Schmidt, director of clinical services for Emmanuel hospice, stated that on 08/11/2020 Resident A was prescribed Morphine 20 mg/ml once a day at bedtime and PRN once a day. Resident A's August 2020 Medication Administration Record indicates Resident A was administered Morphine .25 mg by licensee Tammy Plescher on 08/02/2020 and 08/04/2020 at 08:00 PM. A preponderance of evidence was discovered during the Special Investigation to substantiate violation of the applicable rule. Resident A did not receive her Morphine as prescribed in August 2020.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Licensee Gordon Plescher was made trustee of Resident A's trust.

INVESTIGATION: On 07/29/2022 complaint allegations were received from the BCAL online reporting system. The complaint allegations were assigned to me for investigation on 08/02/2022. The complaint included an allegation that licensee Gordon Plescher assisted Resident A with appointing Mr. Plescher as the trustee of her trust.

On 08/02/2022 I interviewed Public Guardian Jan Waterway via telephone. Ms. Waterway stated Resident A was admitted to the facility in December 2019 and at that time Resident A's only living child, Relative 1, was her legal decision maker via a Power of Attorney. Ms. Waterway stated Resident A suffered from dementia and was at the time of admission declared unable to make her own decisions. Ms. Waterway stated in August 2020 licensees Gordon and Tammy Plescher assisted Resident A with removing Relative 1 as her legal decision maker and replaced Mr. Plescher as Trustee over finances. Ms. Waterway stated Mr. Plescher had access to all of Resident A's finances and bank account and had written checks from Resident A's bank account. Ms. Waterway stated there is no indication that Mr. Plescher misappropriated Resident A's funds or used Resident A's funds for Mr. Plescher' s personal gains. Ms. Waterway stated hospice services initiated a petition with the Ottawa Probate court to appoint Resident A a legal guardian and Ms. Waterway was subsequently appointed as such August 2020.

On 08/02/2022 I interviewed Relative 1 via telephone. Relative 1 stated Resident A moved into the facility in December 2019 and at that time was suffering from

memory decline. Relative 1 stated on 01/06/2020 Resident A was declared by two physicians, Dr. Spoolstra (Primary Care Physician) and Dr. Reckow (Neurologist) as unable to make her own decisions thereby enacting Relative 1's Power of Attorney over medical and finances. Relative 1 stated on 08/13/2020 licensees Gordon and Tammy Plescher assisted Resident A with securing a new attorney and drafted a new declaration asserting Mr. Plescher as trustee of Resident A's finances. Relative 1 stated Mr. Plescher had access to all of Resident A's finances and bank account. Relative 1 stated Mr. Plescher wrote checks from Resident A's bank account. Relative 1 stated in August 2020, Emmanuel hospice services filed a petition with the Ottawa County Probate Court requesting a public guardian be appointed for Resident A and subsequently Jan Waterway was appointed as such.

On 08/03/2022 I completed an unannounced onsite investigation at the facility and interviewed licensee Gordon Plescher. Mr. Plescher stated that upon Resident A's admittance to the facility December 2019, Resident A's son was her activated Power of Attorney due to Resident A's memory loss. Mr. Plescher stated on 08/13/2020 he and his wife, licensee Tammy Plescher, assisted Resident A with securing a new attorney and subsequently drafted a new declaration asserting Mr. Plescher as trustee of Resident A's finances. Mr. Plescher acknowledged he was granted and executed the ability to control resident A's finances and wrote checks from her banking account. Mr. Plescher stated in August 2020, Emmanuel hospice services filed a petition with the Ottawa County Probate requesting a public guardian be appointed for Resident A and subsequently Jan Waterway was appointed as such.

On 08/03/2022 I interviewed licensee Tammy Plescher via telephone. Ms. Plescher stated in December 2019 Resident A was admitted to the facility with her son, Relative 1, as Resident A's activated Power of Attorney due to Resident A's memory loss. Ms. Plescher stated that on 08/13/2020 she and licensee Gordon Plescher assisted Resident A with securing a new attorney and subsequently drafted a new declaration asserting Mr. Plescher as trustee of Resident A's finances.

On 08/03/2022 I received and reviewed an email from Relative 1. The email contained four separate documents. The first attached document is entitled "Lemmon letter" and is dated 08/13/2022 and drafted by Attorney Larry A. Lemmon. The document revocated previous agents and installed licensee Gordon Plescher as co-trustee with Resident A over the Frank D. and Resident A Revocable Living Trust Agreement. The document appointed licensee Tammy Plescher as Resident A's Patient Advocate. The second attached document was entitled "Mercy Health Reckow letter" and was drafted by Dr. Jaclyn Reckrow PhD. of Mercy Health on 01/02/2022 with a signature of 01/03/2022. The document stated Resident A was diagnosed with unspecified dementia without behavioral disturbance. The document states Resident A does not have the capacity to understand medical and cognitive status. The document states Dr. Reckrow recommended the activation of Resident A's Durable Power of Attorney for healthcare and finances. The third attached document is entitled "DHHS Beckman letter". The document was drafted by Adult Protective Services staff Ken Beckman and states Relative 1 was "acting within the

scope" of his Power of Attorney regarding Resident A. The third attached document is entitled "Mercy Health Spoolstra letter". The letter is drafted 01/06/2022 by Dr. Spoolstra, MD and states Resident A's "memory is worsening" to the point she was "not able to make health and finance decisions". The document stated that Resident A's "DPOA should "take over".

On 08/16/2022 I completed an Exit Conference via telephone with Licensee Gordon Plescher. Mr. Plescher stated he does not agree with the finding but will submit a Corrective Action Plan.

APPLICABLE RULE	
R 400.1421	**Handling of resident funds and valuables.**
	(7) A resident's account shall be individual to the resident. A licensee shall be prohibited from having any ownership interest in a resident's account and shall verify such in a written statement to the resident or the resident's designated representative.
ANALYSIS:	Licensee Gordon Plescher stated that upon Resident A's admittance to the facility December 2019, Resident A's son was her activated Power of Attorney due to Resident A's memory loss. Mr. Plescher stated on 08/13/2020 he and his wife, licensee Tammy Plescher, assisted Resident A with securing a new attorney and subsequently drafted a new declaration asserting Mr. Plescher as trustee of Resident A's finances. Mr. Plescher acknowledged he was granted and executed the ability to control resident A's finances and wrote checks from her banking account. A document is entitled "Lemmon letter" dated 08/13/2022 revoked previous agents and instated licensee Gordon Plescher as co-trustee with Resident A over the Frank D. and Relative A Revocable Living Trust Agreement. A preponderance of evidence was discovered during the Special Investigation to substantiate a violation of the applicable rule. Licensee Gordon Plescher assisted Resident A in establishing Mr. Plescher as Resident A's trustee over Resident A's Living Trust Agreement and Mr. Plescher wrote checks from Resident A's bank account.
CONCLUSION:	**VIOLATION ESTABLISHED**

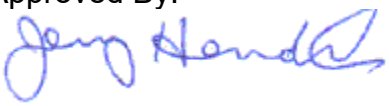
IV. RECOMMENDATION

Upon receipt of an acceptable Corrective Action Plan, I recommend the license remain unchanged.

08/16/2022

Toya Zylstra — Date
Licensing Consultant

Approved By:



08/16/2022

Jerry Hendrick — Date
Area Manager