GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 21, 2024

Abdul Aleem
Plainview Adult Care II, LLC
202 Plainview Dr
Auburn, MI 48611

RE: License #:	AL090413023
Investigation #:	2024A0123048
	Plainview Adult Care II

Dear Abdul Aleem:

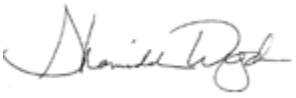
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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 (517) 643-7960.

Sincerely,



Shamidah Wyden, Licensing Consultant
Bureau of Community and Health Systems
411 E. Genesee Ave.
P.O. Box 5070
Saginaw, MI 48607
989-395-6853

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL090413023
Investigation #:	2024A0123048
Complaint Receipt Date:	07/02/2024
Investigation Initiation Date:	07/02/2024
Report Due Date:	08/31/2024
Licensee Name:	Plainview Adult Care II, LLC
Licensee Address:	202 Plainview Dr Auburn, MI 48611
Licensee Telephone #:	(989) 662-7202
Administrator:	Abdul Aleem
Licensee Designee:	Abdul Aleem
Name of Facility:	Plainview Adult Care II
Facility Address:	202 Plainview Dr Auburn, MI 48611
Facility Telephone #:	(989) 662-7202
Original Issuance Date:	12/18/2023
License Status:	REGULAR
Effective Date:	06/18/2024
Expiration Date:	06/17/2026
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
On 06/13/2024, during second shift, Resident A had gotten outside of the building numerous times. Staff did not know, and Resident A was walked back to the facility by a neighbor. Resident A got out again and was in the middle of the parking lot at night. Staff were not able to talk Resident A back inside. 911 was called that night. Staff were able to talk Resident A back into the building.	No
Staff Aaron Kroll was a third shift worker who was very violent and aggressive with female residents. Staff Aaron Kroll was fired due to another staff finding Staff Aaron Kroll's weed peen in a chair.	No
The facility has hired a staff person who is under age 18.	Yes
Manager Rachel Morgan talks to Resident B daily and has shared confidential information about other residents to Resident B.	No

III. METHODOLOGY

07/02/2024	Special Investigation Intake 2024A0123048
07/02/2024	Special Investigation Initiated - On Site I conducted an unannounced on-site at the facility.
07/08/2024	Contact- Document Received Requested documentation received via email.
07/15/2024	Contact- Document Sent APS Referral completed.
07/30/2024	Contact - Telephone call made I interviewed staff Aaron Kroll.
07/30/2024	Contact - Telephone call made I made an attempted call to staff Michelle Ashby.
07/30/2024	Contact - Telephone call made I left a voicemail requesting a return call from staff Holli Yax.
08/02/2024	Contact - Telephone call received I received a voicemail from staff Holli Yax.

08/07/2024	Contact - Document Sent I sent a request to the Bay County Sheriff's Office.
08/07/2024	Contact - Telephone call made I interviewed staff Holli Yax.
08/07/2024	Contact- Document Received I received a response from the Bay County Sheriff's Office.
08/13/2024	Contact- Document Sent I sent a follow-up email to manager Rachel Morgan.
08/13/2024	Contact- Document Received I received an email response from manager Rachel Morgan.
08/14/2024	Inspection Completed On-Site I conducted a follow-up on-site at the facility.
08/14/2024	Contact- Telephone call received I interviewed staff Individual 1 via phone.
08/15/2024	Contact- Telephone call made I interviewed Resident A and staff Alicia Stack via FaceTime.
08/19/2024	Contact- Telephone call made I made an attempted call to Relative 1.
08/20/2024	Contact- Telephone call made I made an attempted call to Relative 1.
08/20/2024	Exit Conference I spoke with licensee designee Abdul Aleem via phone.

ALLEGATION: On 06/13/2024, during second shift, Resident A had gotten outside of the building numerous times. Staff did not know, and Resident A was walked back to the facility by a neighbor. Resident A got out again and was in the middle of the parking lot at night. Staff were not able to talk Resident A back inside. 911 was called that night. Staff were able to talk Resident A back into the building.

INVESTIGATION: On 07/02/2024, I conducted an unannounced on-site at the facility. I interviewed manager Rachel Morgan. She stated that Resident A has dementia. About two weeks ago, Resident A was in the parking lot. Resident A had a UTI (urinary tract infection). Resident A did not leave the premises. Staff Logan Herzberg and staff Michelle Ashby were working during this incident. Resident A went outside three times that day (06/13/2024). Staff heard the alarm go off twice.

Someone called the police the third time, and the Sheriff's department responded. Resident A was arguing with the police about coming back into the facility. Staff Morgan stated that this is not Resident A's normal behavior, and Resident A can usually be redirected easily. Resident A was treated for a UTI afterwards.

On 07/02/2024, I observed Resident A during my on-site. Resident A was in bed asleep and was not interviewed. Her room appeared clean. No issues were noted. Other residents present in the facility were observed as well during this on-site. No issues were noted.

On 07/02/2024, I interviewed Resident B. Resident B stated that they do not leave their room and denied witnessing any police at the facility. During this interview with Resident B, Relative 2 called Resident B. I spoke with Relative 2 via phone. Relative 2 stated that they visit the facility regularly. When asked if they have ever observed any residents in the parking lot, Relative 2 stated that they know that Resident A is always looking for a cat that Resident A no longer has, and that Resident A tries to leave the facility, but staff redirects Resident A.

On 07/02/2024, I interviewed staff Logan Herzberg at the facility. Staff Herzberg stated that on 06/13/2024, Resident A walked out of the facility to the parking lot three times. Staff Herzberg stated that Resident A must have walked out behind someone else, probably a resident's family because the door alarm did not go off. Staff caught Resident A before Resident A left the parking lot. Staff Herzberg stated that the Sheriff's department was called the first time Staff Herzberg got Resident A from the parking lot. Staff Michelle Ashby was with Resident A during the second incident. Staff Herzberg stated that around 8:00 pm or 9:00 pm Resident A was outside a third time, and he stayed outside with Resident A. Resident A walked loops in the parking lot and was agitated. Resident A sat on a bench for about thirty minutes. Staff Holli Yax arrived at work, and Staff Yax got Resident A to go inside because Resident A had to use the bathroom. Staff Herzberg stated that Resident A has dementia and does not want to be at the facility. Staff Herzberg stated that Resident A was agitated the entire day due to a UTI. Staff Herzberg denied that the police actually came, but they considered calling the police or ambulance to get Resident A inside. Staff Herzberg stated that he stayed past his shift to make calls to the nurse, etc.

On 07/08/2024, I received requested documentation from staff Rachel Morgan. Resident A's *Health Care Appraisal* dated 01/17/2024 states that Resident A is diagnosed with vascular dementia and irritability. Resident A is fully ambulatory. Resident A's *Assessment Plan for AFC Residents* dated 08/03/2023 notes that Resident A can move independently in the community, is capable of following instructions, but often non-compliant, and often displays aggressive verbal behavior towards others.

On 07/30/2024, I made an attempted phone call to staff Michelle Ashby. An unidentified man answered the phone and stated that she was at work.

On 07/30/2024, I made a call to the facility to interview Staff Ashby. I was informed that she was not there, but at another job. On 08/13/2024, I emailed manager Rachel Morgan asking her to have Staff Ashby return my call. Manager Morgan stated that she could text Staff Morgan, but that Staff Morgan quit and is no longer employed at the facility.

On 07/30/2024, I interviewed staff Aaron Kroll via phone. He stated that he worked the night of 06/13/2024. He stated that staff on the previous shift were wrapping up the issue staff were having with Resident A when he arrived at work. He stated that there was speculation that Resident A could have walked out of the front or side door. Staff Kroll denied having any knowledge of Resident A walking beyond the facility's parking lot. He stated that it was not normal behavior for Resident A to go outside until after Resident A's cat was rehomed. He stated that Resident A would pace the floor at night looking for the cat. Staff Kroll stated that staff Logan Herzberg was on the phone when he (Staff Kroll) arrived at work. He stated that the police did show up at the facility.

On 08/07/2024, I sent a letter requesting a copy of the police report regarding Resident A for the incident that occurred on 06/13/2024. I received a response from the Bay County Sheriff's Office, which was a copy of the call log. The documentation notes that a call was made to the police on 06/13/2024 at 22:11:44 (10:11 pm) for "*resident escaped, won't come back in the building*." Staff Holli Yax made the call and reported to dispatch that Resident A was hostile, with a glass in their hand, sitting in front of the building not wanting to come inside. At 22:17:44 the log states "*caller would like to cancel*" because Resident A came inside the building.

On 08/07/2024, I interviewed staff Holli Yax via phone. Staff Yax stated that she was recently fired from the facility. Staff Yax was a third shift staff person. Staff Yax stated that the night of 06/13/2024 was a horrible night. The managers were not answering the phones. Staff Yax pulled into the parking lot and observed staff Logan Herzberg and Resident A in the middle of the parking lot. Staff Yax stated that she was told Resident A had gotten out of the facility about seven times and that an individual at the AFC home next door called the facility asking if Resident A belonged to them. Resident A was very escalated. Staff Yax stated that in her opinion, Resident A should have gone to the hospital, or something should have been done if Resident A's behaviors had been ongoing for hours. Staff Yax stated that Resident A got as far as another AFC home that sits north of the facility's parking lot, or to Midland Road. Staff Yax stated that Resident A was agitated with Staff Herzberg. Resident A sat on the bench with Staff Yax. Staff Yax stated that she tried assisting Resident A for a couple minutes, then called 911. Staff Herzberg called Resident A's nurse. Staff Yax stated Resident A eventually decided to go to the bathroom, so she called 911 back to let them know the police did not need to respond. Resident A was okay, and she got Resident A ready for bed. Staff Yax denied that Resident A had a UTI (urinary tract infection), and said it was just a bad

night for Resident A. Staff Yax stated that since Resident A's cat was taken away, Resident A looks for the cat every night. Resident A is a wanderer.

On 08/14/2024, I conducted a follow-up on-site at the facility to interview Resident A. Upon arrival, I noted there was a sign posted that there were active COVID-19 cases in the home. I spoke with staff Alicia Stack briefly at the door. Staff Stack agreed to do a FaceTime call with me on 08/15/2024. Staff Stack stated that eight residents are positive for COVID-19, including Resident A. I gave Staff Stack my business card to pass to staff Individual 1.

On 08/15/2024, I conducted a FaceTime call with Resident A and staff Alicia Stack.

Resident A was observed in bed. Resident A appeared clean and appropriately dressed. Resident A stated that they want their own freedom and wants to move back home. When asked if they ever go outside in the evening, Resident A stated not really, and there's no reason to. When asked how if Resident A gets along with staff, Resident A said not really because staff are all busy doing their job. Resident A did not remember having a rough night or staff trying to get Resident A back inside the facility.

Staff Stack was interviewed and stated that she was told that Resident A had gotten out and was down by a pizza restaurant near the end of the driveway of the facility's property. Staff Stack stated that Resident A would have been still on the facility's property if still in the driveway when found. Staff Stack stated that she heard a gentleman found Resident A and brought Resident A back to the building. Staff Stack stated that she thinks Resident A was diagnosed with a UTI afterwards. Staff Stack stated that she thinks the door alarms may not have been on that day. Staff Stack stated that Resident A has declined since this incident and does not try to get outside.

APPLICABLE RULE	
R 400.15305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	On 07/02/2024, I conducted an unannounced on-site at the facility. I interviewed manager Rachel Morgan. Rachel Morgan stated that Resident A got outside three times but did not leave the premises. Staff Logan Herzberg was interviewed and stated that Resident A went outside three times, but staff stopped Resident A before Resident A left the parking lot.

	On 07/30/2024, I interviewed staff Aaron Kroll. Staff Kroll denied having any knowledge of Resident A walking beyond the facility's parking lot. On 08/07/2024, I sent a request to the Bay County Sheriff's Office for a copy of a police report. I received a copy of the call logs from 06/13/2024 that confirms a call was made to 911, but also that staff Holli Yax called back and canceled the request for assistance. Staff Holli Yax was interviewed and stated that Resident A got out of the facility about seven times and got as far as Midland Road. On 08/15/2024, I interviewed Resident A who denied remembering being outside and staff trying to get Resident A back inside the facility. I interviewed staff Alicia Stack who stated that she was told that Resident A had walked down the end of the driveway of the facility. There is not a preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Staff Aaron Kroll was a third shift worker who was very violent and aggressive with female residents. Staff Aaron Kroll was fired due to another staff finding Staff Aaron Kroll's weed peen in a chair.

INVESTIGATION: On 07/02/2024, I conducted an unannounced on-site at the facility. I interviewed manager Rachel Morgan. Rachel Morgan stated that a staff person found a marijuana vape pen in a chair that belonged to Staff Kroll. Staff Kroll was starting a lot of drama with staff. Rachel Morgan stated that Staff Kroll was fired. Rachel Morgan stated that all of the residents liked Staff Kroll, as Staff Kroll received compliments, but Staff Kroll was weird acting towards staff and made other staff uncomfortable.

On 07/02/2024, I interviewed Resident B. Resident B stated that there was a male staff that used to work in the facility that treated Resident B very good.

During this interview with Resident B, Relative 2 called Resident B. I spoke with Relative 2 via phone. Relative 2 stated that staff Aaron Kroll took great care of Resident B, and that Relative 2 had no issues with Staff Kroll.

On 07/02/2024, I interviewed staff Logan Herzberg at the facility. Staff Herzberg denied that Staff Kroll was hostile with residents but stated that there was conflict between Staff Kroll and other staff.

On 07/30/2024, I interviewed staff Aaron Kroll via phone. Staff Kroll stated that he started working in the facility in June 2024 and is no longer a staff there as he was fired. Staff Kroll denied that any resident made any complaints about him. Staff Kroll stated that there a couple female residents who preferred not to have personal care done by the opposite sex. Staff Kroll stated that he was fired for poor job performance, and that a weed (marijuana) pen was found. Staff Kroll denied the weed pen was his, and that he was never at work under the influence. Staff Kroll stated that the issues he had at work were with staff Holli Yax who had a bad attitude and she complained a lot. Staff Kroll stated that Staff Yax would say she would call the state on staff and make it uncomfortable for new employees to the point they would quit. Staff Kroll stated that Staff Yax was mean, had an attitude, and was snippy, and that she was short and snappy with the residents. Staff Kroll stated that he never got to sit down with management to talk to them about the issues with Staff Yax.

On 08/07/2024, I interviewed staff Holli Yax via phone. Staff Yax stated that staff Aaron Kroll worked third shift and was fired because a weed (marijuana) pen was found in a chair. Staff Yax stated that Staff Kroll would sleep during the work shift, and a lot of female residents did not like Staff Kroll. Staff Yax stated that residents would say that Staff Kroll was really gruff. Staff Yax stated that Staff Kroll was “weird”, made everything uncomfortable, and threatened another staff person.

On 08/15/2024, I interviewed staff Alicia Stack via FaceTime. Staff Stack stated that she never witnessed Staff Kroll working, and only observed Staff Kroll during shift change. Staff Stack stated that she did not hear of any complaints from residents regarding Staff Kroll. Staff Stack stated that she heard about Staff Kroll’s alleged weed (marijuana) pen. Staff Stack stated that there was never an issue like that prior to Staff Kroll working there.

During this FaceTime call, I also interviewed Resident A. When asked if there were any male staff she’s had any issues with, she stated that they could “*use a better personality*” and that she could not recall anyone specifically.

APPLICABLE RULE	
R 400.15305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	On 07/02/2024, I interviewed manager Rachel Morgan who stated that staff Aaron Kroll was fired, but all of the residents

	liked Staff Kroll, and there were no complaints received regarding Staff Kroll from residents. Relative 2 was interviewed and stated that Staff Kroll took great care of Resident B. Resident B stated that there was a male staff who treated them very good. Staff Logan Herzberg denied that Staff Kroll was hostile with the residents. On 07/30/2024, I interviewed staff Aaron Kroll. Staff Kroll denied the allegations and denied that the weed pen was his and denied ever working under the influence. On 08/07/2024, I interviewed staff Holli Yax who stated that a lot of female residents did not like Staff Kroll and that Staff Kroll had a weed pen that was found. On 08/15/2024, I interviewed staff Alicia Stack who denied hearing of any complaints about Staff Kroll from residents. There is no preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: The facility has hired a staff person who is under age 18.

INVESTIGATION: On 07/02/2024, I conducted an unannounced on-site at the facility. I interviewed manager Rachel Morgan. Staff Morgan stated that Staff Individual 1 is 17 years of age and will be 18 in August 2024. Staff Morgan stated that Staff Individual 1 is not doing any direct care and is not passing medication. Staff Morgan stated that Staff Individual 1 has only worked two shifts to date and is paid.

On 07/02/2024, I interviewed staff Logan Herzberg at the facility. Staff Herzberg stated that Staff Individual 1 does not touch any resident medications, but does assist with brief changes, cleaning, and toileting residents.

On 07/30/2024, I interviewed staff Aaron Kroll via phone. Staff Kroll denied working with anyone who was under the age of 18.

On 08/07/2024, I interviewed staff Holli Yax via phone. Staff Yax stated that staff Individual 1 is an underaged person (age 16) who was hired for third shift. Now staff Individual 1 is the activities manager for the facility. Everyone thought Staff Individual

1 was 18 years old. Staff Yax stated that she worked with Staff Individual 1, and that Staff Individual 1 provided personal care to residents such as changing briefs, toileting, transferring. Staff Yax stated that she was instructed to train staff Individual 1 as a staff person. Staff Yax stated that Staff Individual 1 did everything staff did as a care aide, and there were no restrictions on Staff Individual 1's tasks.

On 08/14/2024, I received a call from staff Individual 1. Staff Individual 1 stated they started working in the facility in late June 2024 as a summer job. Staff Individual 1 confirmed they are 17 years of age. Staff Individual 1 stated that they are a CNA (certified nursing assistant). Staff Individual 1 stated that they just turned 17 years of age but was 16 when they started working. Staff Individual 1 confirmed that when they first started working in the facility, staff Individual 1 was providing personal care to the residents including brief changes, and supervision. Staff Individual 1 stated that they worked about four shifts providing personal care. Staff Individual 1 denied passing medications, assisting with transferring residents on their own, or bathing residents. Staff Individual 1 stated that the four shifts they worked doing personal care, there was only one shift they worked where there were two other staff present, and the other shifts it was Staff Individual 1 and one other staff.

On 08/15/2024, I interviewed staff Alicia Stack via FaceTime. Staff Stack stated that staff Individual 1 was started as a third shift care aide, changing briefs, toileting, doing hands on care. Staff Stack stated that staff Individual 1 is now doing activities with residents four hours a day. Staff Stack stated that staff Individual 1 just turned 17 in August 2024.

On 08/20/2024, I conducted an exit conference with licensee designee Abdul Aleem. I informed him of the findings and conclusion. Abdul Aleem stated that he had no knowledge of a staff person being under age 18 and would address this issue with manager Rachel Morgan.

APPLICABLE RULE	
R 400.15204	**Direct care staff; qualifications and training.**
	(1) Direct care staff shall not be less than 18 years of age and shall be able to complete required reports and follow written and oral instructions that are related to the care and supervision of residents.
ANALYSIS:	On 07/02/2024, I interviewed manager Rachel Morgan who denied that staff Individual 1 was doing any personal care or passing medications. Staff Herzberg was interviewed and stated that staff Individual 1 does not pass medications but has provided residents with personal care. On 08/07/2024, I interviewed staff Holli Yax who also stated

	that staff Individual 1 was under the age of 18 and has provided personal care to the residents. On 08/14/2024, I interviewed staff Individual 1 who confirmed that they were working as a direct care staff person on multiple shifts, and is currently 17 years of age, but was 16 years of age when hired. On 08/15/2024, I interviewed staff Alicia Stack who also confirmed that staff Individual 1 was providing personal care to residents and is under the age of 18. There is a preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Manager Rachel Morgan talks to Resident B daily and has shared confidential information about other residents to Resident B.

INVESTIGATION: On 07/02/2024, I conducted an unannounced on-site at the facility. I interviewed manager Rachel Morgan. She denied the allegations. She stated that she does not know Resident B outside of the facility, and that she (Staff Morgan) is not at the facility daily.

On 07/02/2024, I interviewed Resident B. Resident B stated that they have lived in the facility for about one month. Resident B stated that staff have been fantastic. Resident B stated that they do not leave their room by choice. Resident B stated that staff Rachel Morgan has checked on Resident B a few times and tries to get Resident B to be social with others and come out of their room. Resident B stated that Staff Morgan is professional and denied that Staff Morgan gossips. Resident B stated that they are happy here.

During this interview with Resident B, Relative 2 called Resident B. I spoke with Relative 2 via phone. Relative 2 stated that they visit regularly and denied having any concerns that have not been addressed. Relative 2 stated that they do not have any issues with anyone in the facility, and that Resident B does not come out of their room. Resident B stays to themselves and stays out of drama. Relative 2 denied that Staff Morgan shares personal information regarding others in the facility.

On 07/02/2024, I interviewed staff Logan Herzberg at the facility. Staff Herzberg stated that manager Rachel Morgan usually is not present during his shifts and had no knowledge of the allegation.

On 07/30/2024, I interviewed staff Aaron Kroll via phone. Staff Kroll stated that staff Holli Yax would share information about others to Resident B and Relative 2. Staff Kroll stated that anything that crossed Staff Yax's mind, who was late for work, who didn't show up for work, she told it. Staff Kroll stated that he had no knowledge of any managers sharing confidential information. Staff Kroll stated that Staff Yax told Resident B and Relative 2 about Resident A and how Staff Yax wished Resident A would shut up about Resident A's cat.

On 08/07/2024, I interviewed staff Holli Yax via phone. Staff Yax stated that she works third shift. Staff Yax stated that manager Rachel Morgan was telling Resident B and Relative 2 confidential things. Staff Yax stated that Relative 2 knew that Resident A had a script for Ativan. Relative 2 knew things about the medication room and knew a lot of things about other residents. Staff Yax stated that Relative 2 would say "*Rachel said…*" when talking about things.

On 08/15/2024, I interviewed staff Alicia Stack via FaceTime. Staff Stack stated that Relative 2 knows things that Relative 2 should not know, but Staff Stack stated that she has not heard anything that was resident specific. Staff Stack denied having any knowledge of management sharing any confidential information.

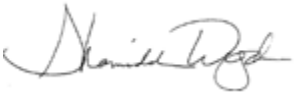
APPLICABLE RULE	
R 400.15304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights: **(q) The right to confidentiality of records as stated in section 12(3) of the act.**
ANALYSIS:	On 07/02/2024, I interviewed manager Rachel Morgan who denied the allegations. On 07/02/2024, I interviewed Resident B and Relative 2 who denied the allegations. I interviewed staff Logan Herzberg who had no knowledge of the allegation. On 07/30/2024, I interviewed staff Aaron Kroll who had no knowledge of management sharing confidential information. On 08/07/2024, I interviewed staff Holli Yax who stated that Staff Morgan was sharing confidential information with Resident B and Relative 2. On 08/15/2024, I interviewed staff Alicia Stack who stated

	Relative 2 knows things they should not know, but that she had not heard of anything specific to residents. There is no preponderance of evidence to substantiate a rule violation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 08/20/2024, I conducted an exit conference with licensee designee Abdul Aleem. I informed Abdul Aleem of the findings and conclusion.

IV. RECOMMENDATION

Contingent upon the receipt of an acceptable corrective action plan, I recommend continuation of the AFC large group home license (capacity 1-20).



08/20/2024

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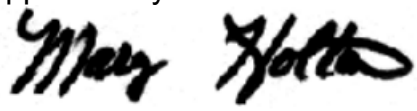
Shamidah Wyden Date
Licensing Consultant

Approved By:



08/21/2024

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Mary E. Holton Date
Area Manager