



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
DIRECTOR

January 16, 2025

Kimberly Singer  
Welcome Home Assisted Living - Owosso  
1605 Vandekarr Rd  
Owosso, MI 48867

RE: License #: AS780402782  
Investigation #: 2025A0584003  
Welcome Home Love

Dear Ms. Singer:

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

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available, and you need to speak to someone immediately, please contact the local office at (517) 284-9727.

Sincerely,

A handwritten signature in cursive script that reads "Candace Coburn". The signature is written in a dark ink and has a fluid, connected style.

Candace Coburn, Licensing Consultant  
Bureau of Community and Health Systems  
611 W. Ottawa Street  
P.O. Box 30664  
Lansing, MI 48909

enclosure

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

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	AS780402782
<b>Investigation #:</b>	2025A0584003
<b>Complaint Receipt Date:</b>	11/20/2024
<b>Investigation Initiation Date:</b>	11/22/2024
<b>Report Due Date:</b>	01/19/2025
<b>Licensee Name:</b>	Welcome Home Assisted Living - Owosso
<b>Licensee Address:</b>	1605 Vandekarr Rd Owosso, MI 48867
<b>Licensee Telephone #:</b>	(989) 723-3807
<b>Administrator:</b>	Kimberly Singer
<b>Licensee Designee:</b>	Kimberly Singer
<b>Name of Facility:</b>	Welcome Home Love
<b>Facility Address:</b>	1607 Vandekarr Rd Owosso, MI 48867
<b>Facility Telephone #:</b>	(989) 723-3807
<b>Original Issuance Date:</b>	02/06/2020
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	08/06/2024
<b>Expiration Date:</b>	08/05/2026
<b>Capacity:</b>	6
<b>Program Type:</b>	AGED

## II. ALLEGATION(S)

	<b>Violation Established?</b>
<b>Resident A did not receive her prescribed medication Torsemide for 6 days</b>	<b>No</b>
<b>Additional Findings</b>	<b>Yes</b>

## III. METHODOLOGY

11/20/2024	Special Investigation Intake - 2025A0584003.
11/22/2024	Special Investigation Initiated - On Site unannounced investigation.  Face to face interview with direct care staff Brooke Sabaj and review of Resident A's facility file.
12/18/2024	Contact - Face to Face interviews with Resident A, Direct care staff Brook Bowen, Sheila Harrow, and Stephanie Orweller.  Exit Conference via a telephone call with Kimberly Singer, licensee designee.
12/27/2024	Contact – Telephone interview with direct care worker Rebecca Beacham.
01/02/2024	Contact – Telephone interview with direct care worker Mary Jo Smith.

### **ALLEGATION:**

**Resident A did not receive her prescribed medication Torsemide for 6 days.**

### **INVESTIGATION:**

On 11/20/2024, the Bureau of Community and Health Systems (BCHS) received the above allegation, via the BCHS online complaint system. The written complaint did not identify the dates and/or times the medication was allegedly not administered.

On 11/22/2024, I conducted an unannounced onsite investigation and interviewed direct care worker Brooke Sabaj, who denied the allegation.

Ms. Sabaj provided me with Resident A's medication administration records (MAR) for the months of October and November 2024. Documentation on Resident A's MARs indicated she was to be administered 20mg of Torsemide, as prescribed, every morning on Sunday, Monday, Wednesday, and Friday. According to documentation on Resident A's MAR, Resident A was administered this medication as prescribed until she entered the hospital on 11/20/2024.

I was unable to interview Resident A, as she was still in the hospital.

On 12/18/2024, I conducted another onsite investigation at the facility and interviewed Resident A in person. Resident A confirmed she had received all of her medication Torsemide as prescribed.

<b>APPLICABLE RULE</b>	
<b>R 400.14312</b>	<b>Resident medications.</b>
	<b>(2) Medication shall be given, taken, or applied pursuant to label instructions.</b>
<b>ANALYSIS:</b>	Based upon my investigation, which consisted of a review of documentation pertinent to this investigation, as well as interviews with Resident A and staff member Brooke Sabaj, there was no evidence to substantiate the allegation that Resident A did not receive her medication Torsemide for six days.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

**ADDITIONAL FINDING:**

**INVESTIGATION:**

On 12/18/2024, Resident A stated that she was concerned that there was only one direct care staff member assigned to care for the six residents who lived at the facility. According to Resident A, there were a few times that, on unknown dates, the one direct care staff working at the facility left the facility for at least 20 minutes, leaving the residents unsupervised.

I attempted to interview the two other residents present at the facility during my on-site investigation. However, they were either unable or unwilling to answer my questions.

I conducted a face to face interview with direct care staff member Sheila Harrow. Ms. Harrow stated she was the building manager of another facility and did not work in this facility. According to Ms. Harrow, she did not hear or witness any direct care staff members leave the facility, leaving residents unattended for any amount of time.

I conducted a face to face interview with Ms. Orweller. Ms. Orweller stated she had left the facility a couple of times for no more than 10 or 15 minutes when she was the only direct care worker scheduled, leaving the residents unsupervised.

On 12/27/2024, I conducted a telephone interview with direct care staff member Rebecca Beacham. Ms. Beacham's statements were consistent to Ms. Orweller.

On 1/30/2025, I conducted a telephone interview with direct care worker Mary Jo Smith. Ms. Smith's statements were consistent with Ms. Harrows.

<b>APPLICABLE RULE</b>	
<b>R 400.14206</b>	<b>Staffing requirements.</b>
	<b>(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.</b>
<b>ANALYSIS:</b>	Based upon my investigation, which consisted of interviews with Resident A and multiple direct care staff members, there was enough evidence to substantiate the allegation the licensee occasionally did not have sufficient direct care staff members on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan. There were occasions when the only direct care staff member scheduled to work in the facility, left the facility, leaving the residents unsupervised.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

On 12/18/2024, I conducted an exit conference with licensee designee Kimberly Singer and informed her the findings of my investigation.

**IV. RECOMMENDATION**

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



1/10/2025

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Candace Coburn  
Licensing Consultant

Date

Approved By:



1/16/2025

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Michele Streeter  
Area Manager

Date