



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

June 27, 2025

Mos, John and Pop, Simion
P O Box 327
2844 Livernois Rd
Troy, MI 48099

RE: License #: AS630409905
Investigation #: 2025A0605012
Springwater

Dear John Mos and Pop Simion:

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 (248) 972-9136.

Sincerely,

A handwritten signature in dark ink, reading "Frodet Dawisha". The signature is written in a cursive, flowing style. The name "Frodet" is written in a larger, more prominent script than "Dawisha".

Frodet Dawisha, Licensing Consultant
Bureau of Community and Health Systems
3026 W. Grand Blvd.
Cadillac Place, Ste 9-100
Detroit, MI 48202
(248) 303-6348

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630409905
Investigation #:	2025A0605012
Complaint Receipt Date:	05/12/2025
Investigation Initiation Date:	05/13/2025
Report Due Date:	07/11/2025
Licensee Name:	Mos, John and Pop, Simion
Licensee Address:	5365 Weston Ct Commerce Township, MI 48382
Licensee Telephone #:	(888) 255-5426
Administrator:	John Mos
Licensee Designee:	John Mos and Simion Pop
Name of Facility:	Springwater
Facility Address:	5873 Springwater Ln West Bloomfield, MI 48322
Facility Telephone #:	(888) 255-5426
Original Issuance Date:	11/29/2022
License Status:	REGULAR
Effective Date:	05/29/2025
Expiration Date:	05/28/2027
Capacity:	4
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
There are concerns for possible sexual assault on Resident A. Staff at the home have their boyfriends over and Resident A woke up a few weeks ago with her underwear inside out.	No
Additional Findings	Yes

III. METHODOLOGY

05/12/2025	Special Investigation Intake 2025A0605012
05/13/2025	Special Investigation Initiated - Letter Email to Oakland County Office of Recipient Rights (ORR)
05/13/2025	APS Referral Adult Protective Services (APS) made referral but will not be investigating these allegations
05/13/2025	Contact - Document Received Email from ORR
05/14/2025	Contact - Document Received Email from ORR
05/14/2025	Contact - Telephone call made With the home manager (HM)
05/15/2025	Inspection Completed On-site Conducted unannounced on-site investigation
05/19/2025	Contact - Document Received Email from licensee designee John Mos
06/03/2025	Contact - Telephone call made Left messages for direct care staff (DCS) Lisa Filiman, Shantel Hightower, Hailee Chambers, and Onyie Awurum
06/03/2025	Contact - Telephone call received Interviewed DCS Lisa Filiman regarding allegations

06/09/2025	Contact - Telephone call made Interviewed DCS Jalisha Ross, Onyie Awurum and licensee designees John Mos and Simon Pop. Left message for DCS Shantel Hightower and Hailey Chambers.
06/18/2025	Contact - Telephone call received Interviewed DCS Shantel Hightower
06/25/2025	Exit Conference Conducted exit conference with licensee designees John Mos with my findings

ALLEGATION:

There are concerns for possible sexual assault on Resident A. Staff at the home have their boyfriends over and Resident A woke up a few weeks ago with her underwear inside out.

INVESTIGATION:

On 05/13/2025, intake #205535 was referred by Adult Protective Services (APS) regarding the caregivers at the group home have their boyfriend's over. A few weeks ago, Resident A woke up and her underwear was turned inside out.

On 05/14/2025, I received an email from Oakland County Office of Recipient Rights (ORR) Rachel Moore. Ms. Moore contacted Resident A who denied being sexually assaulted; therefore, ORR will not be investigating the allegations.

On 05/15/2025, I conducted an unannounced on-site investigation at Springwater. Present was the home manager (HM) Crystal Sterling, Resident A, Resident B, and Resident C. Resident D was at workshop (Our House Club). I interviewed the HM Ms. Sterling regarding the allegations. Ms. Sterling has been working for this corporation for about eight years. She denied staff bringing any boyfriends or any male visitors to this group home as policy states, "no one comes to this home." Residents are not allowed any visitors at night and if they have visitors, it must be approved by Ms. Sterling and by the residents' guardian. Resident A is her own guardian and spends most of her days at her father's home. Resident A never reported to Ms. Sterling that she woke up with her underwear turned inside out or told the HM about any assault. Ms. Sterling received a telephone call from ORR worker Ms. Moore advising Ms. Sterling that Resident A's mother took Resident A to McLaren Oakland Hospital on 05/09/2025 for a pregnancy test. Resident A took two pregnancy tests, one was positive, but then the other was negative. The hospital confirmed it was negative. Ms. Sterling stated the only time she is aware that Resident A went to the hospital was when Ms. Sterling took Resident A to Pontiac General Hospital on 05/02/2025 for an intrauterine device (IUD). Ms. Sterling stated if Resident A was assaulted, it did not occur at this group home. Resident A told

Ms. Moore that Resident D's boyfriend comes to the home at night and "after doing Resident D, he does her (Resident A) and there's all kinds of sex." Resident D does not have a boyfriend. Ms. Sterling believes these are Resident A's delusions as that is one of her diagnoses.

On 05/15/2025, I interviewed Resident A in her bedroom regarding the allegations. Resident A has her own bedroom. Resident A is her own guardian. On Mother's Day, Resident A's mother took her to the hospital because her mother "thought she was pregnant." She and her mother were at a relative's gathering and everyone at the party asked Resident A, "Are you pregnant?" Resident A told them, "No, I'm just fat." After the party they got to the mother's home and her mother had her take a pregnancy test. The test was positive. However, her mother took her to McLaren Oakland Hospital where she took a blood test that was negative. Resident A had an ultrasound showing she was not pregnant but was positive for a urinary tract infection (UTI). Resident A's mother asked Resident A, "Did you have sex with anyone?" Resident A told her mother, "I haven't had sex with anyone, but everyone around me is having sex." Resident A stated she overheard Resident D having sex with her boyfriend named Brian Jones in Resident D's bedroom and then when Resident A woke up the next day, she discovered her underwear was "rolled down a bit." Resident A does not recall when she heard Resident D having sex but then stated, "Brian was my boyfriend and Resident D stole him." She was unable to provide any other details. Resident A denied that staff are bringing their boyfriends to the home or any other men.

On 05/15/2025, I attempted to interview Resident B in her bedroom, but she was lying in bed and stated, "I don't want to talk to you."

On 05/15/2025, I attempted to interview Resident C who was walking around the home and she too stated, "I don't want to talk to you."

On 05/15/2025, I interviewed Resident D at Our Club House regarding the allegations. Resident D does not have a boyfriend and does not know anyone named Brian James. She has not seen any men coming to the home visiting or staff's boyfriends or otherwise. The residents are not allowed any sleepovers at the group home. She described Resident A as "a spit fire who lashes out and talks to herself." Resident A gets picked up a lot by her father, so she is rarely at the group home. She does not know anything about Resident A's underwear being "rolled down a bit," and denied anyone having sex at the group home.

On 05/15/2025, I interviewed Resident D's sister regarding the allegations. Resident D does not have a boyfriend and has never reported any concerns about staff bringing men to the group home.

On 06/03/2025, I interviewed direct care staff (DCS) Lisa Filimon regarding the allegations. Ms. Filimon has been with this corporation for four years and works the afternoon. There are no staff bringing men to the home including Ms. Filimon. She has not heard that Resident A woke up and found her underwear "rolled down a bit." The

residents are not allowed to have overnight visitors, nor do they bring visitors at the home. There is no one having sex at this group home.

On 06/09/2025, I interviewed DCS Jalisha Ross regarding the allegations. Ms. Ross has been working with this corporation since 11/2022. She works both morning and afternoon shifts. There are no staff bringing men to the home including any of the residents or Ms. Ross. Resident D does not have a boyfriend, and no residents are having sex. The only visitors at the home are the guardians of the residents. Resident A has not reported anything to Ms. Ross regarding waking up finding her underwear “rolled down a bit.”

On 06/09/2025, I interviewed DCS Onyie Awurum regarding the allegations. Ms. Awurum has been working for this corporation for four years and works both the afternoon and midnight shifts. There are no staff bringing men to the home including the residents or Ms. Awurum. The only visitors coming to the home are the resident’s family or guardians. There are no overnight guests and no one having sex at this group home. Resident A never reported any concerns to Ms. Awurum including waking up and finding her underwear “rolled down a bit.”

On 06/09/2025, I interviewed licensee designees John Moss and Simon Pop via telephone regarding the allegations. There are no staff that bring any men to the home. Resident A and Resident D are extremely vocal and if there were men coming to the home, both Mr. Moss and Mr. Pop would have been aware. Resident A has not reported anything to either of them regarding anything. Resident D does not have a boyfriend, and no one is having sex at the home.

On 06/18/2025, I interviewed DCS Shantel Hightower regarding the allegations. Ms. Hightower has been working for this corporation for three years and works both the afternoon and midnight shifts. There are no men being brought to the home by Ms. Hightower or any other staff or resident. Resident D does not have a boyfriend nor is she or any other resident having sex at the home. Resident A did not report to Ms. Hightower about her underwear being “rolled down a bit.”

APPLICABLE RULE	
R 400.14204	Direct care staff; qualifications and training
	(2) Direct care staff shall possess all of the following qualifications: (a) Be suitable to meet the physical, emotional, intellectual, and social needs of each resident.
ANALYSIS:	Based on my investigation, staff at Springwater are suitable to meet the needs of Resident A. Resident A denied having sex with anyone and stated she had woken up with her underwear “rolled down a bit.” Resident A denied that staff are bringing their boyfriends or any men to the home. Staff denied that any

	men including anyone's boyfriend visits the home. Resident D denied having a boyfriend and reported that no staff have brought any men to the home. All visitors must be approved by the home manager Crystal Sterling and the residents' guardians.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDINGS:

INVESTIGATION:

On 05/15/2025, Resident D reported that the HM Crystal Sterling has been "stressed out," managing two different homes with this corporation. When Ms. Sterling is "stressed out," she yells and shouts at all the residents. Last week, Resident D asked Ms. Sterling to schedule an appointment for Resident D to see a dentist as her tooth was bothering her and Ms. Sterling "lashed out." Ms. Sterling began yelling at Resident D. This happens often when Ms. Sterling is stressed. Resident D is "afraid," to report because she believes she reported this a year ago to licensee designee John Mos, who contacted Ms. Sterling asking Ms. Sterling to "calm down," but that did not work. Ms. Sterling continues to yell and shout at all the residents.

On 05/15/2025, I interviewed Resident D's sister regarding the allegations. Resident D has reported to her sister that when the HM Ms. Sterling is "stressed out," she can become aggressive with her tone. Ms. Sterling is managing two homes so with that comes stress and seems to try her best, but sometimes Resident D says that Ms. Sterling yells and shouts at all the residents.

On 06/03/2025, I interviewed DCS Lisa Filimon regarding the allegations. Ms. Filimon has heard the HM Crystal Sterling "raise her voice," with all the residents when the residents "act out." DCS Hailee Chambers told Ms. Filimon that Ms. Chambers heard and witnessed Ms. Sterling yell and shout at Resident A and Resident D. Ms. Filimon never reported this to anyone.

On 06/09/2025, I interviewed DCS Onyie Awurum regarding the allegations. Ms. Awurum has never worked with the HM Crystal Sterling. Ms. Awurum has never been informed by any resident or any staff that Ms. Sterling was heard yelling and shouting at the residents.

On 06/09/2025, I interviewed licensee designee John Mos and Simion Pop regarding the allegations. The HM Crystal Sterling has difficulty building relationships with people and may come across as firm; however, they both have not received any complaints from any resident including Resident D about Ms. Sterling yelling and shouting at them. Ms. Sterling has attended a Gentle Teaching course in the past; however, they will be speaking with her regarding these concerns and will complete an in-service training with her regarding these issues.

On 06/16/2025, I interviewed the HM Crystal Sterling regarding these allegations. Ms. Sterling gets blamed for everything because she is the one who typically must make decisions that the residents do not like. For example, Residents A and D get mad at Ms. Sterling because she tells them “No.” When Residents A and D do not get their way, they both think Ms. Sterling favors the other resident more than them. Ms. Sterling denied yelling or shouting at Resident D or any other resident. She stated, “I walk away when they begin arguing with me because I’m not going to argue with any of them.”

On 06/17/2025, I interviewed DCS Jalisha Ross regarding the allegations. Ms. Ross has not worked with the HM Crystal Sterling and has never been informed by any resident or other staff that Ms. Sterling was heard yelling or shouting at any of the residents.

On 06/18/2025, I interviewed DCS Shantel Hightower regarding the allegations. Ms. Hightower has never worked with the HM Crystal Sterling; however, Resident A has talked to Ms. Hightower about the HM “talking to Resident A like a kid.” Also, DCS Hailee Chambers told Ms. Hightower that Ms. Chambers heard Ms. Sterling yell at the resident. Ms. Chambers did not tell Ms. Hightower which resident it was and when this happened. Ms. Chambers said, “Crystal talks to all of them any kind of way.” Ms. Hightower never reported this to anyone.

APPLICABLE RULE	
R 400.14304	Resident rights; licensee responsibilities.
	<p>(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:</p> <p>(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.</p>
ANALYSIS:	Resident A and Resident D were not treated with consideration and respect by the HM Crystal Sterling. Ms. Sterling has been heard yelling and shouting at Resident D by staff members at Springwater. Resident D reported that Ms. Sterling “lashes out,” at her and yell at her when she asks Ms. Sterling to schedule an appointment for her. DCS Hailee Chambers who was a staff member at Springwater reported to several staff that she witnessed Ms. Sterling yell and talk to the residents any kind of way.
CONCLUSION:	VIOLATION ESTABLISHED

INVESTIGATION:

On 05/15/2025, I interviewed Resident D who reported to me that she has not been to a dentist or eye doctor since moving into Springwater. Resident D complained about her tooth hurting her this past weekend to the HM Crystal Sterling who joked about it. Ms. Sterling did not schedule her an appointment to see the dentist. Resident D has asked to see the eye doctor because she was having difficulty seeing for the past two months, but no appointment was scheduled. Resident D stated, "Crystal schedules and takes us to get our injections, but not to our medical appointments we need to go to."

On 05/15/2025, I interviewed Resident D's legal guardian regarding these allegations. The legal guardian was taking Resident D to all her doctor appointments, but since Resident D has moved into Springwater, the legal guardian has not had time but thought that Springwater was required to provide transportation. Resident D has not been to the eye doctor for two years and was complaining about her vision and complained about her tooth hurting but has not seen an eye doctor or a dentist yet.

On 05/15/2025, I contacted HM Crystal Sterling regarding the allegations. Resident D complained about her vision four months ago and Resident D's legal guardian took her to the eye doctor. Ms. Sterling asked Resident D "Where are your glasses?" Resident D said, "In my bedroom." Ms. Sterling told Resident D that her vision issues are because Resident D "isn't wearing the glasses?" Resident D does not wear the glasses inside the house, only when she is out. Ms. Sterling believes Resident D does not wear the glasses is the cause of her vision issues. Ms. Sterling was informed that according to Resident D's legal guardian/mother, Resident D had not been to the eye doctor for two years. Ms. Sterling will reach out to Resident D's legal guardian/mother for the eye doctor's information. Ms. Sterling was also informed that Resident D complained of her tooth hurting and needs to see a dentist. Ms. Sterling stated she found a dentist but because Ms. Sterling was "busy," she was not able to schedule the appointment. Ms. Sterling was informed that she will need to schedule the appointment with the dentist to address Resident D's tooth hurting. She acknowledged.

On 06/03/2025, I interviewed DCS Lisa Filimon regarding the allegations. The HM Crystal Sterling is responsible for scheduling the residents' medical appointments and either Ms. Sterling or staff transport the residents to their appointments. Ms. Filimon stated that whenever Resident A or Resident D ask to see a medical doctor, Ms. Sterling "puts it in the back burner," in scheduling their appointments, because she (HM) says, "they're over exaggerating," when wanting to see the doctor. Ms. Filimon does not believe licensee designees John Mos and Simion Pop are aware of this because they believe Ms. Sterling is doing what she is supposed to do with meeting the medical needs of these residents. Ms. Sterling takes all the residents to receive their injections for their mental health, but the medical appointments are the appointments that Ms. Sterling is falling short on.

On 06/09/2025, I interviewed DCS Onyie Awurum regarding the allegations. Ms. Awurum stated she does not transport residents to doctor appointments because she

works afternoon/midnight shifts. However, one-time Resident B had a cough and Ms. Awurum asked Resident B if she told the HM Ms. Sterling about her cough and Resident B stated, “yes,” but was unclear if Resident B had seen a doctor or not.

On 06/09/2025, I interviewed DCS Jalisha Ross regarding the allegations. Ms. Ross was told by Resident A that whenever she has an appointment scheduled, the HM Ms. Sterling would inform Resident A on the day of the appointment, that the appointment was rescheduled. Resident A told Ms. Ross this has happened multiple times by Ms. Sterling.

On 06/09/2025, I interviewed licensee designees John Mos and Simion Pop regarding the allegations. The HM Crystal Sterling should be scheduling all medical appointments and ensuring all the residents’ medical needs are met. Even though she is a supervisor for two of their group homes, there is no reason for any resident to not get an appointment scheduled. Whenever Mr. Mos and Mr. Pop are at the home, they talk with the residents and no resident has reported to them that they are not taken to their medical appointments. They will address these issues.

On 06/16/2025, I followed up with the HM Crystal Sterling who stated that Resident D has an eye doctor appointment tomorrow 06/17/2025 and has already been to the dentist who will be pulling out her tooth on 07/11/2025.

APPLICABLE RULE	
R 400.14305	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:	Based on my investigation and information gathered, the HM Crystal Sterling was not meeting the personal needs of Resident D at all times. Resident D informed Ms. Sterling about four months ago she needed to see the eye doctor, but Ms. Sterling did not schedule the appointment because she was “busy.” Resident D then complained of her tooth hurting to Ms. Sterling who did not schedule her a dentist appointment. However, since this investigation, Resident D has been to the dentist and to the eye doctor.
CONCLUSION:	VIOLATION ESTABLISHED

INVESTIGATION:

During my on-site investigation on 05/15/2025, while I was interviewing the HM Crystal Sterling, Resident A walked out of her bedroom and up to Ms. Sterling with a clear small

cup full of Resident A's medications saying, "I'm missing one of my pills." She placed the cup on the desk and walked away. Ms. Sterling and I reviewed Resident A's medication log and blister backs and there was one pill missing from the cup that was in a prescription bottle. Ms. Sterling stated that DCS Hailee Chambers administered medications this morning but was not present as she had transported Resident D to workshop. Ms. Sterling stated that Ms. Chambers has been properly trained on medication administration and should have never allowed Resident A to take her cup of medications with her in her bedroom. Resident A does not have authorization from any prescribing physician allowing Resident A to take her medication without supervision.

On 05/15/2025, I interviewed Resident A regarding these allegations. DCS Hailee Chambers worked this morning and passed the medications. Resident A stated, "Hailee pops all my medications and puts them in a cup. She puts everyone's pills in different cups, sets them on top of the cabinet and we must grab our own cup. I grabbed mine and brought it back with me to my bedroom. I didn't take them and then when I looked, I was missing a pill." Ms. Chambers is the only DCS that does this. Resident A stated that all other staff call her to come and take her medications hand her the cup and watch her take her medications.

On 05/15/2025, I interviewed Resident D regarding the allegations. Resident D stated that DCS Hailee Chambers is the only staff that pops all the residents' medications in cups, places the cups on top of the table and each resident comes up and picks out their cup with their medications. All the cups are sitting next to each other and are not labeled with any of the residents' names. Each resident must know their medications to ensure they are choosing the correct cup. She has never picked up any other residents' medications because she stated, "I know all my medications."

On 05/15/2025, I reviewed Resident A's medications and medication log and found the following errors:

- **Dovato 50-300MG**: take one tablet by mouth daily was not in given as per label instructions on 05/15/2025 at 8AM as the pill was not in Resident A's medication cup and DCS Hailee Chambers initialed the medication log.
- **Fluphenazine 10MG**: take one tablet by mouth twice a day was not given on 05/15/2025 at 8AM, but DCS Hailee Chambers initialed the medication log.
- **Hydroxyz HCL 10MG**: take one tablet by mouth twice a day was not given on 05/15/2025 at 8AM, but DCS Hailee Chambers initialed the medication log.
- **Cetirizine 10MG**: take one tablet by mouth daily was not given on 05/15/2025 at 8AM, but DCS Hailee Chambers initialed the medication log.
- **Wellbutrin 100MG**: take one tablet by mouth twice a day was not given on 05/15/2025 at 8AM, but DCS Hailee Chambers initialed the medication log.
- **Lamictal 100MG**: take one tablet by mouth twice a day was not given on 05/15/2025 at 8AM, but DCS Hailee Chambers initialed the medication log.

On 05/19/2025, I received an email from licensee designee John Mos stating that DCS Hailee Chambers submitted her two-week notice on 5/12/2025, but she has decided to resign immediately instead of completing the notice period.

On 06/03/2025, I interviewed DCS Lisa Filimon regarding the allegations. Ms. Filimon completed medication administration training. She pops one residents' medication at a time, calls them to come and take their medications, watches them take it and then initials the log. She has never popped all the residents' medications, put them in cups and have the residents pick out which cup is there's. Ms. Filimon heard that there is a staff that does this. She believes it is Hailee Chambers who did this, but she is no longer working for this corporation.

On 06/03/2025, I left DCS Hailee Chambers a message. I also left another message on 06/09/2025. Ms. Chambers never returned any of my calls.

On 06/09/2025, I interviewed DCS Onyie Awurum regarding the allegations. Ms. Awurum has completed medication administration training. She follows the 6-Rights of medication administration and has never popped everyone's medications puts them in cups and has the residents pick out which one is there's. She does not know any staff that has done this because she believes everyone follows the 6-Rights.

On 06/09/2025, I interviewed DCS Jalisha Ross regarding the allegations. Ms. Ross has completed medication administration training. She too follows the 6-Rights of medication administration. She never pops all the residents' medications at once. She pops one resident at a time and watches them take the medications and then initials the log. She does not know of any staff that pops all the medications at once and has the resident pick out their cup with medications.

On 06/09/2025, I interviewed licensee designees John Mos and Simion Pop regarding the allegations. Staff are regularly sent reminders about following the medication administration protocol to ensure that that medications are administered properly. They talked to DCS Hailee Chambers who told them she popped Resident A's medications and Resident A refused to take her medications. Ms. Chambers left the cup on top of the cabinet and informed the HM Crystal Sterling that the cup was sitting there. Ms. Chambers left to transport Resident D to workshop and did not know what happened to the cup full of medications. Ms. Chambers then quit. Mr. Mos and Mr. Pop will conduct an in-service with all staff including the HM regarding proper procedures on medication administration.

On 06/18/2025, I interviewed DCS Shantel Hightower regarding the allegations. Ms. Hightower has completed medication administration training. She too follows the 6-Rights of medication administration. She only pops one residents' medication at a time, watches them take the medication and then initials the medication log. She has never popped all the residents' medications and placed them in cups on the table and had residents pick out which cup belongs to them. She does not know any staff who does this.

On 06/25/2025, I conducted the exit conference with licensee designee John Moss with my findings. Mr. Mos will be submitting a corrective action plan.

APPLICABLE RULE	
R 400.14312	Resident medications.
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	<p>During my on-site investigation on 05/15/2025, Resident A still had her pills in a cup with her in her bedroom. I reviewed Resident A's medications and medication logs and found the following errors:</p> <ul style="list-style-type: none"> • Dovato 50-300MG: take one tablet by mouth daily was not given as per label instructions on 05/15/2025 at 8AM as the pill was not in Resident A's medication cup and DCS Hailee Chambers initialed the medication log. • Fluphenazine 10MG: take one tablet by mouth twice a day was not given on 05/15/2025 at 8AM as it was still in the cup. • Hydroxyz HCL 10MG: take one tablet by mouth twice a day was not given on 05/15/2025 at 8AM, as it was still in the cup. • Cetirizine 10MG: take one tablet by mouth daily was not given on 05/15/2025 at 8AM, as it was still in the cup. • Wellbutrin 100MG: take one tablet by mouth twice a day was not given on 05/15/2025 at 8AM, as it was still in the cup. • Lamictal 100MG: take one tablet by mouth twice a day was not given on 05/15/2025 at 8AM, as it was still in the cup.
CONCLUSION:	VIOLATION ESTABLISHED

APPLICABLE RULE	
R 400.14312	Resident medications.
	(3) Unless a resident's physician specifically states otherwise in writing, the giving, taking, or applying of prescription medications shall be supervised by the licensee, administrator, or direct care staff.

ANALYSIS:	During my on-site investigation on 05/15/2025, DCS Hailee Chambers popped Resident A's medications, placed them in a cup and did not supervise Resident A in taking the medications. Resident A had the cup of medications with her in her bedroom. According to the HM Crystal Sterling, Resident A must be supervised when taking her medications.
CONCLUSION:	VIOLATION ESTABLISHED

APPLICABLE RULE	
R 400.14312	Resident medications.
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: (a) Be trained in the proper handling and administration of medication.
ANALYSIS:	DCS Hailee Chambers did not follow proper medication administration as she pops all of the residents' medications, places them in cups on top of the cabinet/table and each resident must pick up their own cup. Ms. Chambers does not supervise the residents when administering their medications. Ms. Chambers is no longer an employee with this corporation.
CONCLUSION:	VIOLATION ESTABLISHED

APPLICABLE RULE	
R 400.14312	Resident medications.
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: (b) Complete an individual medication log that contains all of the following information: (v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.

ANALYSIS:	<p>During my on-site investigation, I reviewed Resident A's medications and medication logs and found the following errors:</p> <ul style="list-style-type: none"> • Dovato 50-300MG: take one tablet by mouth daily was not given as per label instructions on 05/15/2025 at 8AM as the pill was not in Resident A's medication cup and DCS Hailee Chambers initialed the medication log. • Fluphenazine 10MG: take one tablet by mouth twice a day was not given on 05/15/2025 at 8AM, but DCS Hailee Chambers initialed the medication log. • Hydroxyz HCL 10MG: take one tablet by mouth twice a day was not given on 05/15/2025 at 8AM, but DCS Hailee Chambers initialed the medication log. • Cetirizine 10MG: take one tablet by mouth daily was not given on 05/15/2025 at 8AM, but DCS Hailee Chambers initialed the medication log. • Wellbutrin 100MG: take one tablet by mouth twice a day was not given on 05/15/2025 at 8AM, but DCS Hailee Chambers initialed the medication log. • Lamictal 100MG: take one tablet by mouth twice a day was not given on 05/15/2025 at 8AM, but DCS Hailee Chambers initialed the medication log.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

Contingent upon receiving an acceptable corrective action plan, I recommend no change to the status of the license.

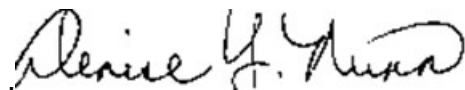


06/25/2025

Frodet Dawisha
Licensing Consultant

Date

Approved By:



06/27/2025

Denise Y. Nunn
Area Manager

Date