GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 21, 2025

Tamesha Porter
Safe Haven Assisted Living, LLC
981 Jolly Road
Okemos, MI 48864

RE: License #: AM330349436
Investigation #: 2025A1033049
Safe Haven Assisted Living

Dear Ms. Porter:

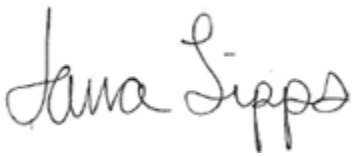
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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) 335-5985.

Sincerely,



Jana Lipps, 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

License #:	AM330349436
Investigation #:	2025A1033049
Complaint Receipt Date:	07/16/2025
Investigation Initiation Date:	07/16/2025
Report Due Date:	09/14/2025
Licensee Name:	Safe Haven Assisted Living, LLC
LicenseeAddress:	981 Jolly Road Okemos, MI 48864
Licensee Telephone #:	(517) 574-4579
Administrator:	Tamesha Porter
Licensee Designee:	Tamesha Porter
Name of Facility:	Safe Haven Assisted Living
Facility Address:	981 Jolly Road Okemos, MI 48864
Facility Telephone #:	(517) 574-4579
Original Issuance Date:	02/07/2014
License Status:	REGULAR
Effective Date:	07/29/2024
Expiration Date:	07/28/2026
Capacity:	12
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
During the month of June 2025, Resident A fell three times at the facility due to lack of supervision from direct care staff. On 7/10/25, Complainant made a visit to Resident A and could hear her screaming for help from the front door. Direct care staff, Crystal Cody, was found playing on her cell phone, ignoring Resident A's screams.	No
The direct care staff did not assist Resident A with meals and fluid intake when Resident A was not capable of completing these tasks independently.	No
Direct care staff, Crystal Cody, administered Resident A's morphine medication incorrectly by administering 0.1ml instead of 1.0ml, as ordered. Ms. Cody refused to administer Resident A's morphine on 7/10/25 at 9:40pm.	Yes
Direct care staff are leaving medications in resident bedrooms and not supervising residents taking their medications.	Yes
Ms. Cody is not trained in administering medications.	Yes
The facility is not properly equipped with linens and Resident A's family had to provide their own linens when Resident A's bed was soiled with urine.	No

III. METHODOLOGY

07/16/2025	Special Investigation Intake 2025A1033049
07/16/2025	Special Investigation Initiated – Letter- Email correspondence with Adult Foster Care Licensing, Area Manager, Dawn Timm.
07/25/2025	Inspection Completed On-site- Interviews conducted with Resident B, licensee designee, Tamesha Porter (via telephone), and direct care staff/facility manager, Grace Chamberlain. Review of Resident A's resident record and direct care staff, Crystal Cody's employee record. Walk through of facility conducted.
07/25/2025	Contact - Document Sent- Email correspondence sent to licensee designee, Tamesha Porter, and direct care staff/facility manager, Grace Chamberlain, requesting additional documentation.
07/29/2025	Contact - Document Received- Email correspondence received from licensee designee, Tamesha Porter.

08/12/2025	Contact – Telephone call received- Interview conducted with Gentiva Hospice nurse, Lauren Anzell. Voicemail message left, awaiting response.
08/12/2025	Contact – Telephone call made- Attempt to interview direct care staff, Levi Stowers. Voicemail message left, awaiting response.
08/20/2025	APS Referral – No referral made, as Resident A is deceased.
08/21/2025	Exit Conference Conducted via telephone with licensee designee, Tamesha Porter.

ALLEGATION:

- **During the month of June 2025, Resident A fell three times at the facility due to lack of supervision from direct care staff. On 7/10/25, Complainant made a visit to Resident A and could hear her screaming for help from the front door. Direct care staff, Crystal Cody, was found playing on her cell phone, ignoring Resident A's screams.**
- **The direct care staff did not assist Resident A with meals and fluid intake when Resident A was not capable of completing these tasks independently.**

INVESTIGATION:

On 7/16/25 I received an online complaint regarding the Safe Haven Assisted Living of Okemos, adult foster care facility (the facility). The complaint alleged that direct care staff are not providing adequate supervision and protection as Resident A experienced three falls at the facility in the month of June 2025. I interviewed Complainant on 7/16/25, via telephone. Complainant reported that they had a telephone conversation with Relative A1, who reported Resident A had at least three falls at the facility in the month of June 2025. Complainant reported that Relative A1 stated that they observed Resident A to be left in soiled bedding that was soaked with urine. Complainant further reported that Relative A1 alleged that direct care staff, Crystal Cody, was found playing on her cellular telephone and not attending to Resident A as she was screaming for assistance on 7/10/25. Complainant also stated that Relative A1 reported direct care staff were not providing adequate nutrition and fluid intake to Resident A as she was not capable of feeding herself or getting her own drink due to advanced Parkinson's Disease and dementia.

On 7/25/25 I conducted an unannounced, on-site investigation at the facility. I interviewed direct care staff/facility manager, Grace Chamberlain, regarding the allegations. Ms. Chamberlain reported that Resident A was admitted to the facility on 4/30/25 and died at the facility on 7/11/25. She reported that Resident A was receiving hospice services through Gentiva Hospice and her hospice nurse was Lauren Anzell. Ms. Chamberlain reported that she was only aware of one fall Resident A experienced while at the facility. She reported that this fall occurred while the hospice nurse was

present providing for Resident A's care. Ms. Chamberlain reported that Resident A was attempting to transfer to her bedside commode, in her resident bedroom, and slipped on urine and fell. Ms. Chamberlain reported that the nurse was present and provided assistance and care immediately. Ms. Chamberlain reported that Resident A was not injured because of this fall. Ms. Chamberlain reported that when Resident A first admitted to the facility, she was more independent and would wear her call button on a lanyard, around her neck. She reported that as she declined, Resident A would keep her call button attached to her wheelchair. She reported that when Resident A first admitted to the facility, she could feed herself and drink independently. She reported that Resident A could hold cups and silverware, until her final three to four days of her life, where direct care staff would need to assist with this task. Ms. Chamberlain did not have knowledge of an incident where Ms. Cody was found not attending to Resident A as she was screaming for assistance. Ms. Chamberlain reported that Ms. Cody is no longer employed at the facility.

On 7/25/25 I interviewed licensee designee, Tamesha Porter, via telephone, during my on-site investigation. Ms. Porter reported that the Gentiva Hospice staff (name not provided) stated that Resident A had a history of confusion and dishonest behaviors. She reported that this information was shared with Ms. Porter prior to Resident A being admitted to the facility. Ms. Porter reported that Ms. Cody worked at the facility occasionally and was not a regular direct care staff member. She reported that Ms. Cody has since been terminated due to allegations of neglect made by Relative A1.

On 7/25/25, during the on-site investigation, I interviewed Resident B regarding the allegations. Resident B reported that she has resided at the facility for the past four years. She reported that the direct care staff assist all residents with personal care and hygiene needs. She reported that residents who cannot feed themselves are fed by the direct care staff. She stated that all residents are supplied with a call button for safety reasons. Resident B reported no knowledge of direct care staff neglecting to provide for resident care or any safety concerns at the facility.

During the on-site investigation on 7/25/25 I reviewed the following documentation:

- Direct care staff schedule for the month of June 2025. I observed that Ms. Cody was not scheduled to work at the facility on 07/10/2025.
- *Health Care Appraisal*, for Resident A, dated 4/28/25. Under section, *7. Diagnoses*, it reads, "Parkinson disease, Anemia, Decreased cardiac output." Under section, *10. General Appearance*, it reads, "pale, fragile, weak." Under section, *14. Special Dietary Instructions and Recommended Caloric Intake*, it reads, "normal diet as tolerated." Under section, *16. Other Health-Related Information or Concerns*, it reads, "No longer able to care for herself, requires assistance with ADL's with frequent cueing."
- *Resident Care Agreement*, for Resident A, dated 4/30/25. Under section, *The basic fee includes the following basic services*, it reads, "All ADL's".
- *Assessment Plan for AFC Residents,* for Resident A, dated 4/24/25. On page two under the section, *II. Self Care Skill Assessment*, subsection, *A. Eating/Feeding*, the document indicates that Resident A does not require assistance with this

area. Under subsection, *G. Walking/Mobility*, it reads, “Wheelchair, 1 person assist.”

- *Resident Weight Record,* for Resident A. This document lists Resident A’s weight as 156lbs on 5/2025 and 155.8lbs on 6/2025.
- *[Resident A’s] 1-Hour Checks.* Ms. Chamberlain explained that when Resident A started to transition at the end of life and the hospice team reported she was actively dying, the direct care staff provided one-hour safety checks. This document notes one-hour checks being completed by direct care staff from 7/9/25 at 9am through 7/11/25 at 12pm.
- *Michigan Workforce Background Check,* for Ms. Cody, dated 1/30/25. This document notes that Ms. Cody “Is Eligible” to work at an adult foster care facility and provide direct care.
- *Safe Haven Assisted Living, Manager Statement.* Ms. Chamberlain reported that she wrote this statement based on interactions she had with Relative A1 on 7/11/25. Ms. Chamberlain reported that Relative A1 had left a voicemail message for her around 4:48pm on 7/11/25 and noted she was upset with the care Ms. Cody was providing for Resident A. The document reported that Relative A1 felt Resident A was not being attended to quickly enough and required assistance with an incontinence brief change. Ms. Chamberlain reported that Ms. Cody was consulted regarding this complaint and Ms. Cody reported that she was the only direct care staff on-site at the time and was preparing dinner, assisting another resident and their home care nurse with a catheter issue, and then going to be attending to Resident A. Ms. Chamberlain reported that she had changed Resident A at 3pm prior to leaving the facility and she had done so with the assistance of the hospice nurse.
- *Written Warning Confidential,* for Ms. Cody. This document was obtained from Ms. Cody’s employee file and dated 7/15/25. Under the section, *Details of Incident*, it reads, “Police arrived stating family is accusing [Ms. Cody] of neglect. Complaint from staff.” Under the section, *Further Action*, it reads, “Termination on 7/15/25”.
- Written Statement from Ms. Cody, dated 7/15/25. This document reads, “So the day that I worked 7/10/2025 I was serving dinner at the time and [Resident A’s] daughter wanted me to change her but I was still in the process of doing dinner at that time after I was done serving dinner. I went and changed [Resident A] her daughter did help me change her because she wanted to help me. And I did pass her morphine I did give her a lower amount I thought it was 0.1 because there was 2 number 1’s on the syringe. I made that mistake because I never passed liquid morphine before just the tabs but I did check on [Resident A] every hour as well and made sure she was comfortable and to see if her daughter needed anything as well I did the best I can do to provide as much care as she needs. I am the only person here as well so I have to make sure the other residents are getting care of as well. Also on this day a hospice nurse came in so I could help him change someone elses [sic] catheter. So I was doing my best to make sure all the resident were getting cared for I can only do my best and if [Resident A’s] daughter felt some kind of way that wasn’t my intention and I’m sorry for that. I can only do my best.”

On 7/25/25 I sent email correspondence to Ms. Chamberlain and Ms. Porter and requested clarification on the direct care staff schedule that was reviewed during the on-site investigation. This schedule did not list Ms. Cody as scheduled to work at the facility on 7/10/25. On 7/29/25 Ms. Porter responded to this email inquiry and reported that Ms. Cody did work at the facility on 7/10/25.

On 7/29/25 Ms. Porter provided documentation, via email, that Ms. Cody had completed a medication administration training in February 2025.

On 8/12/25 I interviewed Gentiva Hospice, registered nurse, Lauren Anzell, regarding the allegations. Ms. Anzell reported that she was Resident A's hospice nurse and had been providing care for her since prior to her move to the facility. Ms. Anzell reported that Resident A moved to the facility at the end of April 2025. Ms. Anzell reported that she would make unannounced visits to the facility and she did not have any concerns regarding the care being provided to Resident A in terms of personal care/hygiene. She reported that she was always able to locate a direct care staff member and the direct care staff were responsive to her questions and requests for Resident A. Ms. Anzell reported that Resident A did experience two to three falls while she resided at the facility. She reported that these falls did not result in injury and generally occurred because Resident A would attempt to transfer herself from her bed to her bedside commode and fall while transferring. Ms. Anzell reported that Resident A confirmed that this is how the falls occurred and stated that Resident A was given a call button to call for direct care staff but would often choose not to use her call button as she was very independent. Ms. Anzell reported that she never found Resident A to be in soiled clothing or linens when she arrived to provide care. She reported that the direct care staff would frequently offer Resident A food and water and she observed this on numerous occasions. Ms. Anzell reported that she has no concerns that Resident A was not offered food and water and noted that there was a point when Resident A was physically declining, where she had to advise the direct care staff to not push food and water due to concerns for aspiration. Ms. Anzell reported that near the end of Resident A's life she was not taking in food and water and then rallied one day and was more alert and able to eat and drink and the direct care staff requested guidance with whether this was okay, as they were previously directed to watch Resident A for signs of aspiration. Ms. Anzell reported that she has no concerns that Resident A's safety, protection, and personal needs were not being attended to and feels the direct care staff met Resident A's needs regarding these areas.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.

ANALYSIS:	Based upon interviews conducted with Complainant, Ms. Chamberlain, Ms. Porter, Resident B, and Ms. Anzell, and documentation reviewed, it can be concluded that there is not adequate evidence to suggest that the direct care staff were not providing for the personal care, protection, and safety of Resident A. It was noted by Ms. Chamberlain and Ms. Anzell that Resident A would attempt to transfer from her bed to bedside commode without assistance from direct care staff and that she did sustain falls with no injury. It was also noted that she was provided with a call button and would choose not to use this device. There was not clear evidence that Resident A was not being provided with food and water by direct care staff. Resident B acknowledged that she has observed direct care staff feed residents and Ms. Anzell reported that she directly observed direct care staff providing food and hydration to Resident A. Also, Resident A's assessment plan did not indicate that she required assistance with feeding from direct care staff. When I conducted an unannounced visit to the facility, I completed a walkthrough and did not find any residents who were in soiled clothing or bedding. Due to a lack of evidence, a violation will not be established at this time.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

- **Direct care staff, Crystal Cody, administered Resident A's morphine medication incorrectly by administering 0.1ml instead of 1.0ml, as ordered.**
- **Ms. Cody refused to administer Resident A's morphine on 7/10/25 at 9:40pm.**
- **Direct care staff are leaving medications in resident bedrooms and not supervising residents taking their medications.**
- **Ms. Cody is not trained in administering medications.**

INVESTIGATION:

On 7/16/25 I received an online complaint regarding the facility. The complaint alleged that Ms. Cody did not administer Resident A's morphine correctly and was only administering 0.1ml when the prescribed dosage was 1.0mls. The complaint also stated that Ms. Cody refused to administer Resident A's morphine medication on 7/10/25 at 9:40pm and that another direct care staff had to be requested to administer this dose. The allegations reported that Ms. Cody was not competent at administering medications as she did not understand the instructions from the physician regarding proper administration of Resident A's morphine medication. On 7/16/25 I interviewed the Complainant via telephone. Complainant reported that she had a telephone

conversation with Relative A1, who stated the reported allegations were correct. She reported that Relative A1 also alleged that the direct care staff were not supervising Resident A in taking her medications and would leave the medications sitting on the bedside table in Resident A's bedroom.

On 7/25/25 I conducted an unannounced investigation at the facility. I conducted a walkthrough of the facility as soon as I arrived. I did not find any evidence of loose medications being left unattended in common areas or in resident bedrooms during this walkthrough.

During the on-site investigation on 7/25/25 I interviewed Ms. Chamberlain regarding the allegations. Ms. Chamberlain reported that Resident A was prescribed morphine for pain control. She reported that this prescription was initially written as an as needed medication, but the last two weeks of Resident A's life, the medication was ordered to be administered routinely. Ms. Chamberlain reported that she has never observed direct care staff members leaving resident medications in their rooms and not observing the resident take their medications. She reported that direct care staff are trained to watch residents take their medications and then mark them as administered. Ms. Chamberlain reported that Ms. Cody did acknowledge a knowledge deficit when it came to understanding Resident A's morphine administration. She reported that Resident A was scheduled to have morphine routinely, every eight hours, but also had an as needed order for the morphine to be administered for breakthrough pain relief if necessary. Ms. Chamberlain reported that on 7/10/25, Relative A1 had requested Ms. Cody administer an as needed dosage of the morphine to Resident A and Ms. Cody was uncertain if she should do so as she did not observe Resident A to be in pain and felt she was resting comfortably. Ms. Chamberlain reported that Ms. Cody did end up administering the dose of morphine that had been requested by Relative A1 on 7/10/25. Ms. Chamberlain reported that it was brought to her attention that Ms. Cody had been administering the wrong dose of morphine to Resident A. She reported that Ms. Cody was confused by the dosing syringe provided and thought she was to be administering 0.1mls instead of 1.0mls. This was brought to Ms. Chamberlain's attention as Ms. Cody had asked direct care staff, Levi Stowers, about the morphine dosing and Mr. Stowers realized Ms. Cody had been giving the wrong dose after speaking with Ms. Cody. Ms. Chamberlain reported that Ms. Cody was taught about administering morphine medication during her medication training class.

During the on-site investigation on 7/25/25 I reviewed the following documents:

- *Medication Administration Record* (MAR) for Resident A for the month of July 2025.
    - *Morphine SUL SOL 100/5ML, Give 1ML (30mg) by mouth or sublingually every 2 hours as needed for pain or shortness of breath.* The MAR indicates that a dose of morphine was administered to Resident A on 7/10/25 at 10:04pm by Mr. Stowers. Ms. Cody initialed the MAR as having administered the morphine to Resident A twice on 7/9/25 and once on 7/10/25.

- *IPSG Pharmacy Controlled Substance Proof of Use Record* for Resident A's Morphine medication. This document is signed on 7/10/25 at 10:02pm by Mr. Stowers.
- *Written Warning Confidential,* for Ms. Cody. This document was obtained from Ms. Cody's employee file and dated 7/14/25. Under the section, *Date of Deficiency*, it reads, "7/10/25". Under the section, *Plan for Improvement*, it reads, "More training on meds and care." Under the section, *Further Action*, it reads, "If like incident happens again employee will be terminated."
- Written Statement from Ms. Cody, dated 7/15/25. This document reads, "So the day that I worked 7/10/2025 I was serving dinner at the time and [Resident A's] daughter wanted me to change her but I was still in the process of doing dinner at that time after I was done serving dinner. I went and changed [Resident A] her daughter did help me change her because she wanted to help me. And I did pass her morphine I did give her a lower amount I thought it was 0.1 because there was 2 number 1's on the syringe. I made that mistake because I never passed liquid morphine before just the tabs but I did check on [Resident A] every hour as well and made sure she was comfortable and to see if her daughter needed anything as well I did the best I can do to provide as much care as she needs. I am the only person here as well so I have to make sure the other residents are getting care of as well. Also on this day a hospice nurse came in so I could help him change someone elses catheter. So I was doing my best to make sure all the resident were getting cared for I can only do my best and if [Resident A's] daughter felt some kind of way that wasn't my intention and I'm sorry for that. I can only do my best."

On 8/12/25 I interviewed Ms. Anzell via telephone regarding the allegations. Ms. Anzell reported that she did recall occasions she would make an unannounced visit to the facility and find medications left on Resident A's bedside table in a medication cup. She reported that when this happened, a direct care staff was not present in the room with Resident A and the medications were left on the bedside table, unattended. Ms. Anzell reported that she had a conversation with the direct care staff and educated them that this was a dangerous practice as any of the residents could wander into Resident A's bedroom and take these medications. Ms. Anzell reported that she observed this situation a couple of times and after the education she provided it appeared to improve and she was no longer finding unattended medications at Resident A's bedside table. Ms. Anzell reported that Relative A1 made verbal complaints to her that a direct care staff member at the facility was not administering morphine correctly. Ms. Anzell could not recall the name of the direct care staff member during this interview. She reported that she did provide education to the direct care staff on proper administration of morphine medication.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(2) Medication shall be given, taken, or applied pursuant to label instructions.
ANALYSIS:	Based upon the interviews conducted with the Complainant, Ms. Chamberlain, & Ms. Anzell, as well as documentation reviewed it can be determined that Ms. Cody did not administer the correct dosage of morphine to Resident A on 7/9/25 & 7/10/25. Ms. Cody acknowledged through her written statement dated 7/15/25 that she did not understand how to properly administer the morphine as she thought the order was written for 0.1mls instead of the actual order of 1.0mls. This statement along with the verbal reports from Ms. Chamberlain and Relative A1's report to the Complainant aligns with the allegation that Resident A was not administered the correct dosage of her morphine. Therefore, a violation has been established.
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:	Based upon the interviews conducted with Complainant, Ms. Chamberlain, and Ms. Anzell, it can be determined that the direct care staff had left Resident A's medications unattended on her bedside table in her bedroom. Ms. Anzell reported that she directly observed this occurrence and provided education to the direct care staff on the dangers of this practice. Complainant acknowledged that Relative A1 also observed Resident A's medications to be left unattended on her bedside table. As a result a violation has been established at this time.
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:	Based upon interviews conducted with Complainant, Ms. Chamberlain, & Ms. Anzell, as well as documentation reviewed it can be determined that Ms. Cody did receive medication administration training in February 2025. However, based on Ms. Cody's written statement on 7/15/25, it can also be determined that she acknowledged she was not fully competent in administering morphine, yet administered Resident A's morphine medication on 7/9/25 & 7/10/25. Ms. Porter was able to demonstrate that Ms. Cody did receive training in medication administration, however there was no verification Ms. Cody was adequately trained in the use of syringes needed to administer medication. Ms. Cody, by her own admission, did not understand how to properly fill a syringe to the prescribed amount and thus was not properly trained.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: The facility is not properly equipped with linens and Resident A's family had to provide their own linens when Resident A's bed was soiled with urine.

INVESTIGATION:

On 7/16/25 I received an online complaint regarding the facility. The complaint alleged that the facility is not adequately equipped with bed linens. On 7/16/25 I interviewed Complainant who reported that she had spoken with Relative A1 who stated that she went to visit Resident A at the facility and her bed linens were soaked with urine and there were no clean linens available at the facility to change the sheets on Resident A's bed. Relative A1 reported to Complainant that she had to retrieve a sheet from her vehicle in order to change the linens on Resident A's bed on 7/10/25.

On 7/25/25 I conducted an unannounced on-site investigation at the facility. I conducted a walkthrough of the facility and observed where extra bed linens are kept. I observed three large shelves in the laundry area where blankets, sheets, and pillow cases were kept. I observed an adequate supply of extra bed linens for resident use, as well as all resident beds were equipped with clean bedding during this on-site investigation.

During the on-site investigation on 7/25/25 I interviewed Resident B regarding the allegation. Resident B reported that she has resided at the facility for the past four

years. She reported that bed linens are changed when soiled and at least once a week on shower days. Resident B reported never experiencing a time when clean bed linens were not available for resident use.

During the on-site investigation on 7/25/25 I interviewed Ms. Chamberlain regarding the allegation. Ms. Chamberlain reported that she is aware of the situation that occurred on 7/10/25 with Resident A's sheets. She reported that on this date there were multiple showers that occurred along with other residents having incontinence issues on their bedding. She reported direct care staff were required to launder multiple resident beddings on this date and all of the back up fitted sheets were in the washer and dryer due to this issue. She reported that Relative A1 noted that Resident A's bedding was soiled and Ms. Chamberlain explained to her that they could lay down a flat sheet until the fitted sheets, which were in the dryer, were finished drying. Ms. Chamberlain reported that Relative A1 chose to get a fitted sheet from her vehicle instead of using the flat sheet while they waited for a dry fitted sheet.

APPLICABLE RULE	
R 400.14411	**Linens,**
	(1) A licensee shall provide clean bedding that is in good condition. The bedding shall include 2 sheets, a pillow case, a minimum of 1 blanket, and a bedspread for each bed. Bed linens shall be changed and laundered at least once a week or more often if soiled.
ANALYSIS:	Based upon interviews with the Complainant, Resident B, and Ms. Chamberlain, as well as observations made during the on-site investigation, it can be determined that there is not substantial evidence to determine that the facility has not been adequately stocked with bed linens for current residents. Ms. Chamberlain reported that on 7/10/25 they experienced an influx in bedding to launder due to regularly scheduled showers and incontinence issues. She reported that she offered a clean flat sheet for Resident A's bed while the dryer was processing a clean fitted sheet and Relative A1 declined this solution. I observed adequate bedding in storage at the facility during the on-site investigation. Therefore, a violation will not be established at this time.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an approved corrective action plan, no change to the status of the license recommended at this time.

8/21/25

_____

Jana Lipps Date
Licensing Consultant

Approved By:

08/21/2025

_____

Dawn N. Timm Date
Area Manager