GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 24, 2025

Kory Feetham
Big Rapids Fields Assisted Living LLC
4180 Tittabawassee Rd
Saginaw, MI 48604

RE: License #: AL540402190
Investigation #: 2025A1033059
Big Rapids Fields Assisted Living

Dear Mr. Feetham:

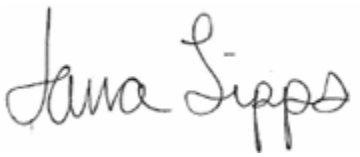
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 #:	AL540402190
Investigation #:	2025A1033059
Complaint Receipt Date:	09/16/2025
Investigation Initiation Date:	09/17/2025
Report Due Date:	11/15/2025
Licensee Name:	Big Rapids Fields Assisted Living LLC
LicenseeAddress:	18900 16 Mile Road Big Rapids, MI 49703
Licensee Telephone #:	(989) 450-8323
Administrator:	LaTasha Elton
Licensee Designee:	Kory Feetham
Name of Facility:	Big Rapids Fields Assisted Living
Facility Address:	18900 16 Mile Road Big Rapids, MI 49307
Facility Telephone #:	(810) 931-1961
Original Issuance Date:	12/21/2020
License Status:	REGULAR
Effective Date:	06/21/2025
Expiration Date:	06/20/2027
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Direct care staff Chris Boyer, did not wait for assistance in transferring Resident A, which caused her pain and discomfort.	No
Direct care staff, Chris Boyer, did not provide Resident A with dignity and respect while providing for her personal care.	Yes
ADDITIONAL FINDINGS	Yes

III. METHODOLOGY

09/16/2025	Special Investigation Intake 2025A1033059
09/16/2025	APS Referral- Denied APS referral.
09/17/2025	Special Investigation Initiated - On Site- Interview conducted with Administrator, LaTasha Elton, review of direct care staff, Chris Boyer's, employee file. Review of Resident A's resident record initiated. Review of direct care staff schedule initiated.
09/22/2025	Contact – Telephone call made- Interview conducted with Harmony At Home Hospice RN, Theresa Hazen, via telephone.
09/22/2025	Contact – Telephone call made- Interview conducted with direct care staff, Chris Boyer, via telephone.
09/22/2025	Contact – Telephone call made- Attempt to interview direct care staff, Ahnaviya Know, via telephone. There was no answer and no way to leave a voicemail message.
09/23/2025	Contact – Document received- Email correspondence received from Ms. Elton.
09/24/2025	Exit Conference conducted via email with licensee designee, Kory Feetham, and Administrator, LaTasha Elton.

ALLEGATION:

- **Direct care staff, Chris Boyer, did not wait for assistance in transferring Resident A, which caused her pain and discomfort.**
- **Direct care staff, Chris Boyer, did not provide Resident A with dignity and respect while providing for her personal care.**

INVESTIGATION:

On 9/16/25 I received an online complaint regarding the Big Rapids Fields, adult foster care facility (the facility). The complaint alleged that direct care staff, Chris Boyer, did not provide Resident A with dignity and respect when transferring her while providing

personal care, and failed to wait for an additional direct care staff member to assist with Resident A's personal care, resulting in discomfort and pain. I was unable to interview Complainant as this complaint stemmed from a denied Adult Protective Services referral.

On 9/16/25 I received email correspondence from Adult Foster Care Licensing Consultant, Jennifer Browning. Ms. Browning forwarded an email correspondence she received from facility administrator LaTasha Elton. Ms. Elton sent this email correspondence to Ms. Browning on 9/16/25. She identified that Mr. Boyer has been placed on a leave of absence from the facility due to a family member coming forward with concerns that Mr. Boyer handled their loved one in a "rough" manner when providing care. She reported that the family member noted they did not think Mr. Boyer was acting in an abusive manner, just that he was rushing through his work and not taking time with the resident. This email did not identify which resident or family member Ms. Elton was referencing. Ms. Elton reported that Mr. Boyer has been removed from the facility schedule until a full investigation has been completed.

On 9/17/25 I conducted an unannounced, on-site investigation at the facility. I interviewed Ms. Elton on this date. Ms. Elton reported on 9/14/25 there was a complaint about Mr. Boyer moving too quickly through his tasks. She reported that there was a concern regarding Mr. Boyer's performance while assisting direct care staff, Ahnaviyah Knox, in providing personal care to Resident A. Ms. Elton reported that a complaint arose as Mr. Boyer went into Resident A's bedroom and told Ms. Knox that he could assist her with changing Resident A's incontinence brief but he needed to make it quick as he was also preparing to serve dinner. She reported that it was described to her that Mr. Boyer took Resident A's legs, as she lay in her bed, and lifted them straight up in the air, like you would if you were changing an infant. Ms. Elton reported that Relative A1 was in the room and observed this as well as Ms. Knox. Ms. Elton reported that Mr. Boyer continued to hold Resident A's legs up in the air so that Ms. Knox could clean her peri area and then lay her legs back down on the bed once completed. Ms. Elton reported direct care staff members are taught to roll a bed bound, incontinent resident from side to side to perform an incontinence brief change to ensure the most comfort and dignity during this process. Ms. Elton reported that she spoke with Relative A1, after this incident was reported to her. She reported that Relative A1 stated that she did not think Mr. Boyer was acting in an abusive manner, but she did feel as though he was rushing through the care he was providing. Ms. Elton reported that Mr. Boyer has been employed at the facility since March 2024. She reported that he was previously on the midnight shift (11pm-7am) and two months ago switched to working days (7am to 3pm). Ms. Elton reported that she has since had to counsel Mr. Boyer on a couple occasions for the use of vulgar language in the presence of residents. She reported that this was not language directed at the residents, but language residents did overhear. She reported that she has taken complaints from other direct care staff members about Mr. Boyer rushing through the care he is providing to residents. Ms. Elton reported that she feels the transition from nights to days has been stressful on Mr. Boyer as he is not used to the level of activity and change in responsibility that occurs as the day shift has more responsibility for resident care and can be busier than the night shift. Ms. Elton

reported that additional training is planned for Mr. Boyer on resident rights and resident personal care. Ms. Elton reported that Mr. Boyer is currently on a leave of absence pending the outcome of the investigation.

During the on-site investigation on 9/17/25, I reviewed the following documents:

- Comfort Care Senior Living, *Corrective Action*, for Mr. Boyer, dated 9/15/25. Under the section, *Incident Description*, it reads, "[Mr. Boyer] has been heard using profanity in the dining room and hallways during his shift. On several occasions it has been reported that [Mr. Boyer] is not using a second person for 2 person transfers – most recently Theresa RN [Theresa Hazen] witnessed this with [Citizen 1]. [Citizen 2] states [Mr. Boyer] rushes her and doesn't allow her to transfer because "I'm too slow"." This document is signed by Mr. Boyer and Ms. Elton and witnessed by Operations Manager, Bettie Hubbard, on 9/15/25.
- Comfort Care Senior Living, *Corrective Action*, for Mr. Boyer, dated 9/15/25. Under section, *Incident Description*, it reads, "On 9/15/25 it was reported to management that a resident complained of [Mr. Boyer] being rough with a resident." This document is signed by Mr. Boyer and Ms. Elton and witnessed by Operations Manager, Bettie Hubbard, on 9/15/25.
- *Michigan Workforce Background Check*, Eligibility Letter, for Mr. Boyer, dated 5/22/24. This document indicates that Mr. Boyer, "Is Eligible", to work in an adult foster care facility.
- I reviewed Mr. Boyer's completed direct care staff trainings with the following observations:
    - Resident Rights training, 100%.
    - Personal Care, 83%.
    - Safety in Transfers, 91%

  I asked Ms. Elton what a passing score for these trainings is and she noted the direct care staff must reach an 80% or higher to be determined as competent in these trainings.
- *Assessment Plan for AFC Residents*, for Resident A, dated 5/1/25. On page two, under section, *II. Self Care Skill Assessment*, subsections, *B. Toileting, C. Bathing, E. Dressing, F. Personal Hygiene*, each area has the written notation, "Needs cues". I inquired of Ms. Elton what Resident A's current needs were in these areas and she reported that up until two months ago, Resident A could perform these tasks independently with cues from direct care staff. She reported that Resident A was admitted to hospice care on 7/11/25 and now requires complete assistance with these tasks from direct care staff members.
- Ms. Elton shared a text message exchange between herself and Ms. Knox that was recorded in their scheduling application for the facility. This exchange occurred on 9/16/25. Ms. Elton asked Ms. Knox if she had witnessed any staff member being rough or inappropriate with "room 11" [Resident A]. Ms. Knox replied, "I witnessed [Mr. Boyer] lift [Resident A] by her legs, in a way similar to how you would lift a baby, instead of rotating her during a change. Initially when I asked for help, it was to reposition her but then I noticed her brief was wet. When I mentioned it, he responded that we needed to hurry up so he could get back to finishing up dinner (not exact wording, but very close) I felt like the comment was

rude especially to say in front of family." Ms. Elton then asked Ms. Knox if Resident A was showing any signs of being in pain during this process to which Ms. Know replied, "Yes, she made groaning noises."

On 9/22/25 I interviewed Harmony At Home Hospice, Registered Nurse, Theresa Hazen, regarding the allegation. Ms. Hazen reported that she was the hospice nurse for Resident A. She reported that Resident A died on 9/18/25, at the facility, under hospice services. Ms. Hazen reported that she is aware of the allegations against Mr. Boyer and she feels these allegations have been taken "too far". She reported that she did receive a comment from Relative A1 noting Mr. Boyer came into Resident A's room and performed personal care in a quick manner and "manhandled" Resident A. Ms. Hazen reported that upon further conversation Relative A1 stated that she did not find the care to be abusive, but did feel Mr. Boyer rushed through the care he provided and quickly turned Resident A in her bed. Ms. Hazen reported that she spoke with Mr. Boyer about needing to use two direct care staff members instead of providing the care himself. I inquired whether it was in Resident A's plan of care to have two direct care staff provide for her personal care, transfers, scheduled turning in her bed. Ms. Hazen reported that she does not feel she ever put this in writing, but she felt it was common knowledge that was stated, verbally, to direct care staff. I inquired if Ms. Hazen had ever directly observed Mr. Boyer not working with two direct care staff when it was the expectation for any other residents at the facility. Ms. Hazen reported that she had no direct knowledge of this happening. Ms. Hazen reported that she has directly observed Mr. Boyer providing direct care to residents at the facility and she has not found the care he provides to be abusive. She reported that he is direct with residents and could be "softer" with them in terms of taking time and not rushing through care, but she has not found him to be abusive. Ms. Hazen reported that Resident A had a long and slow physical decline. She reported that Resident A would frequently moan out when being repositioned or provided personal care. Ms. Hazen reported that it would not have been uncommon for the resident to grimace or make a noise when Mr. Boyer moved her body to provide care.

On 9/22/25 I interviewed Mr. Boyer, via telephone, regarding the allegation. Mr. Boyer reported that on 9/14/25 he assisted Ms. Knox with changing Resident A's incontinence brief. He reported that he did tell Ms. Knox that she needed to hurry up with the care she was providing as he had dinner to attend to, as well. He reported that he made this statement because Ms. Knox takes a long time when providing care and he wanted her to know that he did not have time to waste as he had other tasks to perform. Mr. Boyer reported that Resident A's legs are contracted, which means her legs will not straighten out and are stuck in a bent position. He reported that it is easier to change her incontinence brief by picking up her bottom off the mattress as you would do with an infant. He reported that when you attempt to roll her from side to side this method does not work well due to her contracted legs. He reported that on this date he did pick up her legs to allow Ms. Knox to remove the soiled brief and place the clean brief under Resident A. Mr. Boyer reported that he did not feel he was rude to Resident A or Ms. Knox during this interaction. Mr. Boyer reported that he is not certain if it was ever documented that Resident A required a two-person assist with personal care, but he

noted that two direct care staff members were routinely used due to the care she required. Mr. Boyer reported that he never provided independent care to Resident A. He reported that any resident at the facility who requires a two-person assist with personal care, transfers, or mobility is offered two direct care staff. He reported that he has never provided independent care to a resident who requires a two-person assist. He reported that it is communicated to the direct care staff from Ms. Hazen or from the administration via email whether someone requires a two-person assist. Mr. Boyer reported that he is not certain where this information would be documented in the resident record.

On 9/23/25 I received email correspondence from Ms. Elton in response to additional questions I emailed her on 9/22/25. Ms. Elton reported that Citizen 1 and Citizen 2 identified in the Corrective Action document for Mr. Boyer reside in the neighboring licensed adult foster care facility. Ms. Elton reported that when she consulted Mr. Boyer regarding these claims, he did not deny the allegations written on the Corrective Action documents. She reported that he signed these documents willingly in the presence of Ms. Hubbard. Ms. Elton reported that when a resident requires a two-person assist with mobility, transfers, and/or personal care, this will be identified on the *Medication Administration Record* and the assessment plan. Ms. Elton reported that she had never observed Mr. Boyer transfer a resident who required a two-person assist, independently. She reported that Mr. Boyer also did not deny the allegations when counseled regarding his job performance.

APPLICABLE RULE	
R 400.15303	**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 the interviews conducted and documentation reviewed, there is not a preponderance of evidence to suggest that Mr. Boyer provided Resident A's care independently. The incident in question refers to Mr. Boyer's behavior while he was assisting Ms. Knox in providing care to Resident A. Mr. Boyer did provide for the care she required on this date and did not cause physical harm to Resident A. Therefore, a violation has not been established.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

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: **(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy.** **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**
ANALYSIS:	Based upon interviews conducted and documentation reviewed it can be concluded that there is substantial evidence to determine that Mr. Boyer was not providing Resident A with respect and personal dignity on 9/14/25. Two eyewitnesses on this date, Relative A1 and Ms. Knox, reported to Ms. Hazen and Ms. Elton that they observed Mr. Boyer rush through the care provided to Resident A by making rude statements that he had other tasks to attend to and lifting Resident A's legs up off the bed in a "rough" manner, as though she were an infant. Mr. Boyer signed a written *Corrective Action* statement dated 9/15/25, attesting to what was observed of the care he provided to Resident A and acknowledging that he had been heard using profanity in the presence of residents. Mr. Boyer does deny that he was rude when providing care to Resident A on 9/14/25 but also acknowledged that he did make the statement to Ms. Knox to hurry up, because she works slower than he prefers and he had other tasks to accomplish. Mr. Boyer did not take into consideration that Resident A and Relative A1 deserve to be treated with dignity and respect and rushing through providing her personal care does not offer Resident A the level of dignity and respect that she should receive.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 9/17/25 I conducted an unannounced, on-site investigation at the facility. I interviewed Ms. Elton on this date. Ms. Elton was asked about Resident A's current care needs. She reported that Resident A requires complete assistance with her personal care and transfers due to her declining medical condition. She reported that Resident A is currently on hospice care and is bedbound. During this on-site investigation I reviewed the document, *Assessment Plan for AFC Residents*, for Resident A, dated 5/1/25. On page two, under section, *II. Self Care Skill Assessment*, subsections, *B. Toileting, C. Bathing, E. Dressing, F. Personal Hygiene*, each area has the written notation, "Needs cues". I inquired of Ms. Elton when Resident A's care needs changed.

She reported that up until two months ago, Resident A could perform these tasks independently with cues from direct care staff. She reported that Resident A was admitted to hospice care on 7/11/25 and now requires complete assistance with these tasks from direct care staff members. Ms. Elton reported that Resident A's assessment plan should have been updated to reflect this change in condition.

APPLICABLE RULE	
R 400.15301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(4) At the time of admission, and at least annually, a written assessment plan shall be completed with the resident or the resident's designated representative, the responsible agency, if applicable, and the licensee. A licensee shall maintain a copy of the resident's written assessment plan on file in the home.
ANALYSIS:	Based upon the interview conducted with Ms. Elton and review of Resident A's assessment plan it can be concluded that Resident A's care needs changed significantly, from her being able to provide for her own personal care, hygiene, toileting, and dressing with just verbal cues, to requiring full assistance with these tasks. However, her assessment plan was not updated to reflect this change in condition.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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


9/23/25

Jana Lipps Date
Licensing Consultant

Approved By:


09/24/2025

Dawn N. Timm Date
Area Manager