



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
DIRECTOR

September 22, 2025

Renee Reynolds  
Mulberry Senior Residence, LLC  
18854 Parke East Ct.  
Riverview, MI 48193

RE: License #: AS820382528  
Investigation #: 2025A0116042  
Mulberry Senior Residence

Dear Ms. Reynolds:

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 (313) 456-0439.

Sincerely,

A handwritten signature in blue ink that reads "Pandrea Robinson". The signature is written in a cursive, flowing style.

Pandrea Robinson, Licensing Consultant  
Bureau of Community and Health Systems  
Cadillac Pl. Ste 9-100  
3026 W. Grand Blvd  
Detroit, MI 48202  
(313) 319-9682

enclosure

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

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	AS820382528
<b>Investigation #:</b>	2025A0116042
<b>Complaint Receipt Date:</b>	08/13/2025
<b>Investigation Initiation Date:</b>	08/13/2025
<b>Report Due Date:</b>	10/12/2025
<b>Licensee Name:</b>	Mulberry Senior Residence, LLC
<b>Licensee Address:</b>	18854 Parke East Ct. Riverview, MI 48193
<b>Licensee Telephone #:</b>	(734) 250-1812
<b>Administrator:</b>	Renee Reynolds
<b>Licensee Designee:</b>	Renee Reynolds
<b>Name of Facility:</b>	Mulberry Senior Residence
<b>Facility Address:</b>	17928 Reynolds Riverview, MI 48193
<b>Facility Telephone #:</b>	(734) 225-1104
<b>Original Issuance Date:</b>	10/28/2016
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	04/28/2025
<b>Expiration Date:</b>	04/27/2027
<b>Capacity:</b>	6
<b>Program Type:</b>	AGED ALZHEIMERS

## II. ALLEGATION(S)

	<b>Violation Established?</b>
Two staff are not trained in CPR.	No
<ul style="list-style-type: none"> <li>• Resident A and B had/have untreated urinary tract infections (UTIs).</li> <li>• Resident F was sleeping in Resident A's bed with her and staff did not know.</li> <li>• A few months ago, Resident C fell and broke her leg due to staff negligence.</li> </ul>	No
Medication cabinet is kept unlocked.	Yes
Residents are underfed.	No
Additional Findings	Yes

*\*All allegations reported were not addressed as they were not rule related\**

## III. METHODOLOGY

08/13/2025	Special Investigation Intake 2025A0116042
08/13/2025	Contact- Telephone call received. Licensee designee, Renee Reynolds.
08/13/2025	Special Investigation Initiated - Telephone Staff, Madalyn Borg. Left a message requesting a return call.
08/13/2025	Contact-Telephone call received. Staff, Madalyn Borg.
08/13/2025	APS Referral Received. APS denied the complaint for investigation.
08/18/2025	Inspection Completed-BCAL Sub. Compliance Staff, Autumn Dziejcz, home manager Christine Balina, Residents D and E, reviewed Resident's A-C records, and five of five employee records.
08/21/2025	Contact - Telephone call made Guardian C1, left a message requesting a return call.

08/21/2025	Contact - Telephone call made Guardian D1.
09/02/2025	Contact - Telephone call made Guardian C1.
09/02/2025	Contact - Telephone call made Guardian B1, left a message requesting a return call.
09/02/2025	Exit Conference Licensee designee, Renee Reynolds.
09/03/2025	Contact - Telephone call received Guardian B1.
09/16/2025	Contact-Telephone call made Staff, Gail Baffi.

**ALLEGATION:**

**Two staff are not trained in CPR.**

**INVESTIGATION:**

On 08/13/25, I received a call from licensee designee Renee Reynolds, who reported that I would likely be receiving a complaint. Ms. Reynolds reported that the daughter of a former Resident (Resident A) was upset with her and making up lies and false allegations regarding her and her staff. Ms. Reynolds believes that one of her current staff, Madalyn Borg, is involved and is sharing information that is not true to Resident A's daughter.

On 08/13/25, I interviewed staff, Madalyn Borg, and she reported that all staff are not trained in all required areas and reported that licensee designee, Renee Reynolds, had the staff doing their training when she knew that I would be coming to the home to complete the renewal inspection. Ms. Borg reported that she is not sure if all the staff are trained in CPR as required.

On 08/18/25, I conducted an unscheduled onsite inspection at the home and interviewed home manager, Christine Balina. Ms. Balina reported that all the staff

are trained in CPR and first aid and that the verification should be in their employee record.

I reviewed five of five employee records, and each employee had verification of CPR and first aid training and certification.

On 09/02/25, I conducted the exit conference with licensee designee, Renee Reynolds, and informed her of the findings of the investigation. Ms. Reynolds agreed with the findings.

<b>APPLICABLE RULE</b>	
<b>R 400.14204</b>	<b>Direct care staff; qualifications and training.</b>
	<b>(3) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be competent before performing assigned tasks, which shall include being competent in all of the following areas: (c) Cardiopulmonary resuscitation. (b) First aid.</b>
<b>ANALYSIS:</b>	Based on the findings of the investigation, which included an interview with home manager Christine Balina, and my observation, there is not a preponderance of evidence to substantiate this allegation.  Ms. Balina reported that all staff are trained in CPR, and first aid and verification should be in their record.  This violation is not established as I reviewed five of five employee records and confirmed that all staff were trained in CPR and first aid as required by these rules.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

**ALLEGATION:**

- **Resident A and B had/have untreated urinary tract infections (UTIs).**
- **Resident F was sleeping in Resident A's bed with her and staff did not know.**
- **A few months ago, Resident C fell and broke her leg due to staff negligence.**

## **INVESTIGATION:**

On 08/13/25, I received a telephone call from licensee designee, Renee Reynolds, informing me that the daughter of a former Resident was upset with her and was calling guardians of her current residents making up false allegations regarding the care she and her staff provide. Ms. Reynolds reported the daughter was upset that Resident A had a UTI and was complaining of leg pain. Ms. Reynolds contacted the house doctor who ordered a mobile x-ray and Ms. Reynolds scheduled the x-ray. Resident A's daughter was not satisfied with that so on 08/05/25, she came to the home and took Resident A to the hospital. Resident A was diagnosed with a UTI and a kidney stone. There was no injury to her leg. Resident A was discharged from the hospital and went to a rehabilitation center on 08/10/25. Resident A's daughter informed her that she would not be returning to the home. Resident A's daughter told her that she was going to call APS and other state agencies on her.

Ms. Reynolds shared that Resident B passed away today in the hospital.

On 08/13/25, I interviewed staff, Madalyn Borg, and she reported that Resident A and B both have UTIs and are hospitalized. Licensee designee, Ms. Reynolds, is always hesitant about sending residents to the hospital for UTIs and believes she can treat them at home. Ms. Borg knows, based on the resident's behavior, that they likely have an UTI, but Ms. Reynolds does not allow the staff to make the decision to send residents to the hospital. Once Ms. Reynolds decides to send the residents to the hospital the UTI is really bad.

Ms. Borg denied knowledge of Resident F sleeping in the bed with Resident A. Resident A's bedroom was previously Resident F's and due to his dementia, he will go into Resident A's room thinking that it is his. Resident F is easily redirected by staff and is reminded of where his bedroom is. Ms. Borg reported that she can't speak to what happens on other shifts with other staff, but this has not been an issue when she is working.

Ms. Borg reported that she was not on shift when Resident C fell, but heard that on or about 05/27/25, Resident C got up in the middle of the night to go to the bathroom, fell and broke her leg. Resident C did require the use of a walker, however she did not always use it. Resident C was sent out to the hospital and passed away a few days later. Ms. Borg could not recall who shared the specifics of what happened to Resident C with her.

On 08/18/25, I conducted an unscheduled onsite inspection and interviewed home manager, Christine Balina, staff, Autumn Dziedzic, Residents D and E and reviewed Resident A-C records. Ms. Balina reported that the allegations are false and that the staff provide quality care to all of the residents. She denied that residents don't receive needed care for UTI's and reported that the population they serve often have re-occurring UTI's. When residents start to exhibit certain behaviors that are unusual and/or behaviors escalate, Ms. Balina or Ms. Reynolds will contact the resident's

doctor and obtain and send urine samples to be tested for a UTI. The residents are not kept in the home and treated by Ms. Reynolds. At times the residents do not exhibit symptoms, are sent to the hospital for one thing and during their hospital stay find out they also have a UTI. The home has never had any calls or concerns from the hospitals that treat the residents and have never had any APS involvement/investigations since they were opened.

Ms. Balina denied that Resident F was found by her or any staff sleeping in the bed with Resident A when she lived in the home. Resident F has dementia and that used to be his bedroom. Resident F forgets sometimes and would go in Resident A's bedroom, and she would redirect and remind him where his room is.

Ms. Balina denied that Resident C's death had anything to do with staff negligence. She was not in the home when Resident C fell, however received a call from the staff, Gail Baffi, informing her that Resident C got up to use the restroom, did not use her walker, slipped and fell. Ms. Baffi, called 911 and Resident C was transported to the hospital. Resident C did sustain a broken leg. Resident C was 98 years old and had other health issues. Resident C did not require staff assistance when ambulating or in the restroom. Staff would remind Resident C to use her walker and would assist her as needed. Resident C passed away a few days later in the hospital.

I interviewed staff, Autumn Dziedzic, and she denied the allegations. Ms. Dziedzic reported that the population they serve are prone to UTIs and that when the residents behavior starts to change, they know to contact the house doctor so that a urine test can be ordered. No resident with a known UTI is treated at the home. They are sent out so that the infection is properly treated by their doctor or the hospital. All of the residents have families who are involved with their care. If any of this was really happening the family members and/or medical professionals that frequent the home would have reported it.

Ms. Dziedzic denied that Resident F has ever been found sleeping in the bed with Resident A. Resident F does walk in Resident A's room at times as it used to be his. Resident F has dementia and forgets that that bedroom is no longer his.

Ms. Dziedzic denied that Resident C's death or fall had anything to do with negligence. Ms. Dziedzic was not on shift the morning Resident C fell, but reported the staff provided great care to her and that she thrived in the home. Ms. Dziedzic reported Resident C was 99 years old.

I reviewed Resident's A-C assessment plan and confirmed that none of them were 2 person-assist and Resident C could ambulate with a walker.

I interviewed Residents D and E, and they reported that they like living in the home and that the staff treat them well. They reported that the staff are very helpful and

are available to them if they need their assistance. Neither resident reported any concerns.

On 08/21/25, I interviewed Guadian D1, and he reported that he does not have any concerns regarding the care provided by the staff. Resident D has lived in the home for 15 months and has done very well. Licensee designee, Ms. Reynolds, is a registered nurse and that expertise is an added bonus when it comes to the level of care the residents receive. Guadian D1 reported that his mother lived in the home as well and one of her last wishes was to ensure if her husband required AFC to bring him to this home, because of the positive experience she had living there. Two years later he did what she asked and moved Resident D in and couldn't imagine him living anywhere else.

On 09/02/25, I interviewed Guardian C1, and he reported that the care the staff provided to Resident C was wonderful, and he never had any concerns. On or about May 26, 2025, he received a call from licensee designee, Ms. Reynolds, informing him that Resident C had gotten up to use the restroom, forgot to use her walker and fell in the bathroom. Staff, Gail Baffi, was on shift and called 911. Resident C was transported to the hospital and sustained a broken leg. Resident C always had to be reminded to use her walker, but most times she wouldn't. Nothing he observed indicated any abuse or neglect was going on in the home. Resident C had dementia and was declining prior to her fall. Resident C was too old to have surgery to repair the break in her leg and coupled with her other health issues surgery would have likely killed her. Resident C passed in the hospital a couple days after her fall. Guadian C1 worked as a Children Protective Services investigator for over 20 years and knows what abuse/neglect looks like. That was not the case when it came to his mother. The home and the staff were wonderful.

On 09/02/25, I conducted the exit conference with licensee designee, Renee Reynolds, and informed her of the findings of the investigation. Ms. Reynolds agreed with the findings. Ms. Reynolds was emotional and reported that she and her staff do their best to provide optimal care to each resident. They treat them like family, and she is very upset that someone has called and made false allegations against her and the staff.

On 09/03/25, I interviewed Guardian B1, and he reported that the care at the home was phenomenal, and the staff are fantastic. The allegation that Resident B was not treated for her UTI is totally false. Guardian B1 received a call from licensee designee, Ms. Reynolds, informing him that Resident B was exhibiting behaviors and symptoms consistent with a UTI and that she was going to send her to the hospital. Resident B was hospitalized and the UTI diagnosis confirmed. While being treated for the UTI, Resident B's bodily functions started to shut down, she was unable to

swallow, which ultimately led to her passing. Resident B lived a good life and received the best care at this home.

On 09/16/25, I interviewed staff, Gail Baffi, and she reported that she was on shift the morning Resident C1 fell in the bathroom. Ms. Baffi worked the midnight shift on 05/26/25 from 11:30 p.m. to 7:30 a.m. On the morning of 05/27/25, at around 7:00 a.m. she was in the living room area cleaning up and heard a noise. She went toward the back of the home and saw Resident C on the floor in the bathroom. Resident C reported she slipped somehow and fell. Resident C did not have her walker and admitted to leaving it in her bedroom. Resident C was in pain and could not be moved. Ms. Baffi called 911 and home manager, Chritine Balina. EMS transported Resident C to the hospital and confirmed she had broken her leg from the fall. Ms. Baffi started to cry during the interview and reported she loves all of the residents and misses Resident C. Ms. Baffi was also upset that someone would call and say that the staff was neglectful. Ms. Baffi was extremely sad to hear that Resident C passed away a couple of days later.

<b>APPLICABLE RULE</b>	
<b>R 400.14303</b>	<b>Resident care; licensee responsibilities.</b>
	<b>(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.</b>

<p><b>ANALYSIS:</b></p>	<p>Based on the findings of the investigation, which included interviews with staff, Ms. Borg, home manager, Ms. Balina, staff, Ms. Dziedzic, Residents D-E, Guardians B1, and C1, and staff Gail Baffi, there is not a preponderance of evidence to substantiate the allegations.</p> <p>Ms. Balina and Ms. Dziedzic denied that Resident A and B had untreated UTIs and reported that when the residents exhibit unusual behaviors that are consistent with a UTI, their doctors are contacted and/or they are sent to the hospital for evaluation and treatment.</p> <p>Ms. Balina and Ms. Dziedzic denied that Resident F has ever been found sleeping in bed with Resident A. They admitted that Resident F would enter Resident A's bedroom but was easily redirected to his. Resident F has dementia and that used to be his bedroom.</p> <p>Further, they denied that Resident C's fall was a result of staff negligence. Resident C was able to ambulate with her walker. She did not use her walker on the morning of 05/27/25, fell in the bathroom, and sustained a broken leg.</p> <p>Residents D and E reported that the staff provide good care to them, and they enjoy living in the home. Neither had any concerns to report.</p> <p>Guardian B1 and C1 both denied having any concern regarding the care provided to their loved ones. They both reported that the staff were wonderful, and the care was great. They denied that Resident B or C were neglected in any way.</p> <p>Ms. Baffi denied the allegations and reported that on the morning of 05/27/25, Resident C did not use her walker, suffered a fall in the bathroom, and sustained a broken leg. Ms. Baffi sought immediate treatment for Resident C.</p> <p>This violation is not established as the staff provided supervision, protection and personal care as defined in the act and as specified in the resident's written assessment plan.</p>
<p><b>CONCLUSION:</b></p>	<p><b>VIOLATION NOT ESTABLISHED</b></p>

**ALLEGATION:**

**Medication cabinet is kept unlocked.**

**INVESTIGATION:**

On 08/18/25, I conducted an unscheduled onsite inspection and interviewed staff, Autumn Dziejczak, and home manager, Christine Balina. Ms. Dziejczak reported that medication cabinet is always locked. I asked her to take me to the medication cabinet. Ms. Dziejczak pulled on the knob and the cabinet opened exposing the resident's medications. The cabinet was not locked and there were residents sitting in close proximity to the medication cabinet. Ms. Dziejczak reported that the medication cabinet is usually always locked, however she was unable to provide an explanation as to why it wasn't currently locked.

I interviewed Ms. Balina and she reported that the medication cabinet is normally locked and all staff are aware of that requirement. Ms. Balina retrieved the key and locked the medication cabinet.

I interviewed Resident D and E and they reported that the staff administer their medication and it is kept in the cabinet in the dining room area. They were unable to tell me if the medication cabinet is kept locked as required.

On 09/02/25, I conducted the exit conference with licensee designee, Renee Reynolds, and informed her of the findings of the investigation and the specific rule cited. Ms. Reynolds reported an understanding. Ms. Reynolds reported that all staff are aware that the medication cabinet is to be locked at all times and she will be discussing the matter with her staff.

<b>APPLICABLE RULE</b>	
<b>R 400.14312</b>	<b>Resident medications.</b>
	<b>(1) Prescription medication, including dietary supplements, or individual special medical procedures shall be given, taken, or applied only as prescribed by a licensed physician or dentist. Prescription medication shall be kept in the original pharmacy-supplied container, which shall be labeled for the specified resident in accordance with the requirements of Act No. 368 of the Public Acts of 1978, as amended, being S333.1101 et seq. of the Michigan Compiled Laws, kept with the equipment to administer it in a locked cabinet or drawer, and refrigerated if required.</b>

<b>ANALYSIS:</b>	<p>Based on the findings of the investigation, which included interviews with staff, Ms. Dziedzic, home manager Ms. Balina and my observation, there is a preponderance of evidence to substantiate the allegation.</p> <p>Although both Ms. Dziedzic and Ms. Balina reported that the medication cabinet is always locked, during my onsite inspection, I observed the medication cabinet was unlocked when opened by Ms. Dziedzic.</p> <p>This violation is established as this rule requires all medication to be kept in a locked cabinet or drawer.</p>
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**ALLEGATION:**

**Residents are underfed.**

**INVESTIGATION:**

On 08/18/25, I conducted an unscheduled onsite inspection and interviewed staff Autumn Dziedzic, home manager, Christine Balina, and Resident D and E. Ms. Dziedzic reported that all current residents have good appetites and eat very well. The residents eat three balanced and nutritious meals a day and the residents or their families have never had any complaints.

I interviewed home manager, Christine Balina, and she reported that the residents eat very well, and she does the menus and the majority of the food prep. Ms. Balina reported that she has never received any complaints from the residents or their families about them being underfed.

I interviewed Resident D and E and they reported that the food is really good and they get plenty to eat. Resident D reported that the residents can get seconds if they would like and he normally requests seconds. They both reported eating three meals per day and snacks. Resident E reported that the food is plentiful.

I observed the food supply and found an abundance of food in the refrigerator, freezer and cabinets. There were also plenty of fresh fruits and vegetables.

On 08/21/25, I interviewed Guardian D1, and he reported that Resident D has never complained to him about not getting enough to eat. Resident D is healthy and has not lost any weight so as far as he is concerned, he is consuming enough calories.

This allegation must be a part of the smear campaign by the person upset at Ms. Reynolds.

On 09/02/25, I interviewed Guardian C1, and he reported that Resident C was not underfed, was a healthy weight and ate very well while living in the home.

On 09/02/25, I conducted the exit conference with licensee designee, Renee Reynolds, and informed her of the findings of the investigation. Ms. Reynolds agreed with the findings and reported that the residents eat well and there is plenty of food available to the residents at mealtimes.

<b>APPLICABLE RULE</b>	
<b>R 400.14313</b>	<b>Resident nutrition.</b>
	<b>(1) A licensee shall provide a minimum of 3 regular, nutritious meals daily. Meals shall be of proper form, consistency, and temperature. Not more than 14 hours shall elapse between the evening and morning meal.</b>
<b>ANALYSIS:</b>	<p>Based on the findings of the investigation, which included interviews with staff, Autumn Dziedzic, home manager, Christine Balina, Residents D and E, and Guardians D1 and C1 there is not a preponderance of evidence to substantiate the allegation.</p> <p>Ms. Dziedzic and Ms. Balina reported that the residents have plenty of food available for them to eat and have good appetites.</p> <p>Residents D and E reported that the food is good and plentiful. Resident D reported that he often requests seconds and is given them. They reported eating three meals per day and snacks.</p> <p>Guardian D1 reported that Resident D gets plenty to eat and has never complained to him about having enough to eat. Resident D has not lost any weight, and he has no concerns.</p> <p>GuardianC1 reported that Resident C was a healthy weight while living in the home and ate very well.</p> <p>This violation is not established as the licensee designee, provides 3 regular nutritious meals daily.</p>
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

**ADDITIONAL FINDINGS:**

**INVESTIGATION:**

On 08/18/25, I conducted an unscheduled onsite inspection and reviewed five of five employee records. During my review, I observed that staff, Hunter Yurkovich, and Autumn Dziedzic's, employee record, did not contain proof of completion of the following required trainings: reporting requirements, personal care, supervision, and protection, resident rights, safety and fire prevention, and prevention and containment of communicable diseases. Autumn Dziedzic, has been employed since October of 2024 and Hunter Yurkovich, has been employed since August 3, 2024.

I interviewed Ms. Dziedzic and she reported that she is trained in all required areas and is unsure of why her MALA certificates are not in her record.

I interviewed home manager, Chrisine Balina, and she reported that they use the online MALA training modules and that all staff are trained prior to working alone. Ms. Balina could not provide an explanation as to why the training certificates are not in the employee records.

On 09/02/25, I conducted the exit conference with licensee designee, Renee Reynolds, and informed her of the findings of the investigation and specific rule cited. Ms. Reynolds reported that all staff complete the MALA training, and she is not sure why the certificates are not in their records. Ms. Reynolds added that there was an issue with staff printing the certificates and one time, however, the training was completed. Ms. Reynolds reported that she has purchased a new printer and will ensure that all staff print the certificates at the time they complete the training.

<b>APPLICABLE RULE</b>	
<b>R 400.14204</b>	<b>Direct care staff; qualifications and training.</b>
	<b>(3) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be competent before performing assigned tasks, which shall include being competent in all of the following areas:</b> <b>(a) Reporting requirements.</b>  <b>(d) Personal care, supervision, and protection.</b> <b>(e) Resident rights.</b> <b>(f) Safety and fire prevention.</b> <b>(g) Prevention and containment of communicable diseases.</b>

<b>ANALYSIS:</b>	<p>Based on the findings of the investigation, which included my observation, there is a preponderance of evidence to establish this violation.</p> <p>I reviewed employee records and observed that Mr. Yurkovich and Ms. Dziejdzic's record did not contain verification of the following trainings: reporting requirements, personal care, supervision, and protection, resident rights, safety and fire prevention, and prevention and containment of communicable diseases.</p>
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**INVESTIGATION:**

On 08/18/25, I conducted an unscheduled onsite inspection and reviewed five of five employee records. I observed that staff, Hunter Yurkovich and Autumn Dziejdzic, did not have a physical completed and on file within 30 days of their employment.

On 09/02/25, I conducted the exit conference with licensee designee, Renee Reynolds, and informed her of the findings of my investigation and the specific rule cited. Ms. Reynolds reported that she has got behind on some of the paperwork, however, will make sure that both staff complete a physical and will file it in their record.

<b>APPLICABLE RULE</b>	
<b>R 400.14205</b>	<b>Health of a licensee, direct care staff, administrator, other employees, those volunteers under the direction of the licensee, and members of the household.</b>
	<b>(3) A licensee shall maintain, in the home, and make available for department review, a statement that is signed by a licensed physician or his or her designee attesting to the physician's knowledge of the physical health of direct care staff, other employees, and members of the household. The statement shall be obtained within 30 days of an individual's employment, assumption of duties, or occupancy in the home.</b>

<b>ANALYSIS:</b>	<p>Based on the findings of the investigation, which included my observation, there is a preponderance of evidence to establish this violation.</p> <p>I reviewed employee records and observed that Mr. Yurkovich and Ms. Dziejczak's record did not contain a signed statement by a licensed physician attesting to the physician's knowledge of their physical health within 30 days of employment.</p>
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**INVESTIGATION:**

On 08/18/25, I conducted an unscheduled onsite inspection and reviewed five of five employee records. I observed that staff, Hunter Yurkovich, did not contain tuberculosis testing. Mr. Yurkovich has been employed in the home since August 3, 2024.

On 09/02/25, I conducted the exit conference with licensee designee, Renee Reynolds, and informed her of the findings of the investigation and the specific rule cited. Ms. Reynolds reported an understanding and will ensure that Mr. Yurkovich is sent for tuberculosis testing and his results filed.

<b>APPLICABLE RULE</b>	
<b>R 400.14205</b>	<b>Health of a licensee, direct care staff, administrator, other employees, those volunteers under the direction of the licensee, and members of the household.</b>
	<b>(5) A licensee shall obtain written evidence, which shall be available for department review, that each direct care staff, other employees, and members of the household have been tested for communicable tuberculosis and that if the disease is present, appropriate precautions shall be taken as required by state law. Current testing shall be obtained before an individual's employment, assumption of duties, or occupancy in the home. The results of subsequent testing shall be verified every 3 years thereafter or more frequently if necessary.</b>

<b>ANALYSIS:</b>	Based on the findings of the investigation, which included my observation, there is a preponderance of evidence to establish this violation.  I observed that staff, Hunter Yurkovich's, record did not contain written evidence that he had been tested for communicable tuberculosis prior to his assumption of duties.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**INVESTIGATION:**

On 08/18/25, I conducted an unscheduled onsite inspection and reviewed five of five employee records. I observed that staff, Hunter Yurkovich's, record did not contain verification of education.

On 09/02/25, I conducted the exit conference with licensee designee, Renee Reynolds, and informed her of the findings of the investigation and the specific rule cited. Ms. Reynolds reported an understanding and reported she would obtain the required documents and file them as required.

<b>APPLICABLE RULE</b>	
<b>R 400.14208</b>	<b>Direct care staff and employee records.</b>
	<b>(1) A licensee shall maintain a record for each employee. The record shall contain all of the following employee information: (e) Verification of experience, education, and training.</b>
<b>ANALYSIS:</b>	Based on the findings of the investigation, which included my observation, there is a preponderance of evidence to establish this violation.  I observed that staff, Hunter Yurkovich's, record did not contain verification of education.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**INVESTIGATION:**

On 08/18/25, I conducted an unscheduled onsite inspection and reviewed five of five employee records. I observed that staff, Hunter Yurkovich and Autumn Dziedzic's, employee record did not contain verification of references.

On 09/02/25, I conducted the exit conference with licensee designee, Renee Reynolds, and informed her of the findings of the investigation and the specific rule cited. Ms. Reynolds reported an understanding.

<b>APPLICABLE RULE</b>	
<b>R 400.14208</b>	<b>Direct care staff and employee records.</b>
	<b>(1) A licensee shall maintain a record for each employee. The record shall contain all of the following employee information: (f) Verification of reference checks.</b>
<b>ANALYSIS:</b>	Based on the findings of the investigation, which included my observation, there is preponderance of evidence to establish this violation  I observed that staff, Hunter Yurkovich and Autumn Dziedzic's, employee record did not contain verification of reference checks.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**INVESTIGATION:**

On 08/18/25, I conducted an unscheduled onsite inspection and reviewed Residents A-C records and observed that Resident A did not have an annual health care appraisal completed and on file for 2025. The health care appraisal should have been completed in April of 2025.

On 09/02/25, I conducted the exit conference with licensee designee, Renee Reynolds, and informed her of the findings of the investigation and the specific rule cited. Ms. Reynolds reported an understanding and admitted she fell behind on paperwork.

<b>APPLICABLE RULE</b>	
<b>R 400.14301</b>	<b>Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.</b>
	<b>(10) At the time of the resident's admission to the home, a licensee shall require that the resident or the resident's designated representative provide a written health care appraisal that is completed within the 90-day period before the resident's admission to the home. A written health care appraisal shall be completed at least annually. If a written health care appraisal is not available at the time of an emergency admission, a licensee shall require that the appraisal be obtained not later than 30 days after admission. A department health care appraisal form shall be used unless prior authorization for a substitute form has been granted, in writing, by the department.</b>
<b>ANALYSIS:</b>	Based on the findings of the investigation, which included my observation, there is a preponderance of evidence to establish this violation.  I observed that Resident A's record did not contain a 2025 health care appraisal. The annual health care appraisal was due in April of 2025.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**INVESTIGATION:**

On 08/18/25, I conducted an unscheduled onsite inspection and reviewed Resident A-C's records. I observed that Resident A's 2025 annual written assessment plan was in the record, however, it was not completed as it had not been reviewed and signed by Resident A's guardian.

On 09/02/25, I conducted the exit conference with licensee designee, Renee Reynolds, and informed her of the findings of the investigation and the specific rule cited. Ms. Reynolds reported an understanding.

<b>APPLICABLE RULE</b>	
<b>R 400.14301</b>	<b>Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.</b>
	<b>(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.</b>
<b>ANALYSIS:</b>	Based on the findings of the investigation, which included my observation, there is a preponderance of evidence to establish this violation.  I observed that Resident A's record did not contain a completed annual assessment plan for 2025. The annual assessment plan should have been completed, reviewed with, and signed by Resident A's guardian in April of 2025.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**INVESTIGATION:**

On 08/18/25, I completed an unscheduled onsite inspection and reviewed Resident A-C's records. I observed that Resident A's record did not contain a completed annual care agreement for 2025.

On 09/02/25, I conducted the exit conference with licensee designee, Renee Reynolds, and informed her of the findings of the investigation and the specific rule cited. Ms. Reynolds reported an understanding.

<b>APPLICABLE RULE</b>	
<b>R 400.14301</b>	<b>Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.</b>
	<b>(9) A licensee shall review the written resident care agreement with the resident or the resident's designated representative and responsible agency, if applicable, at least annually or more often if necessary.</b>

<b>ANALYSIS:</b>	<p>Based on the findings of the investigation, which included my observation, there is a preponderance of evidence to establish this violation.</p> <p>I observed Resident A's record did not contain a completed annual care agreement. The care agreement should have been completed in April of 2025.</p>
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**INVESTIGATION:**

On 08/18/25, I conducted an unscheduled onsite inspection and reviewed Resident A-C's records. I observed that Resident B's record did contain monthly weights from February 2024 through July 2025.

On 09/02/25, I conducted the exit conference with licensee designee, Renee Reynolds, and informed her of the findings of the investigation and the specific rule cited. Ms. Reynolds reported that she keeps residents' weights in a separate folder and is not sure why the home manager, Ms. Balina, did not provide them to me when I was onsite.

<b>APPLICABLE RULE</b>	
<b>R 400.14310</b>	<b>Resident health care.</b>
	<b>(3) A licensee shall record the weight of a resident upon admission and monthly thereafter. Weight records shall be kept on file for 2 years.</b>
<b>ANALYSIS:</b>	<p>Based on the findings of the investigation, which included my observation, there is a preponderance of evidence to establish this violation.</p> <p>I observed that Resident B's record did not contain monthly weights from February 2024 through July 2025.</p>
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**INVESTIGATION:**

On 08/18/25, I conducted an unscheduled onsite inspection and interviewed home manager, Christina Balina, and reviewed staff, Hunter Yurkovich and Autumn Dziedzic's records. I observed that neither of their records contained verification that they had been trained in the proper handling and administration of medication. Ms. Balina reported that both Mr. Yurkovich and Ms. Dziedzic administer medication and are both trained. Ms. Balina could not provide an explanation as to why the verification was not in their record.

On 09/02/25, I conducted the exit conference with licensee designee, Renee Reynolds, and informed her of the findings of the investigation and the specific rule cited. Ms. Reynolds reported that all staff are MALA trained, and the completion certificates must not have been printed. Ms. Reynolds reported that if she is unable to reprint them, she will have Mr. Yurkovich and Ms. Dziedzic complete the training again and print the certificates at that time.

<b>APPLICABLE RULE</b>	
<b>R 400.14312</b>	<b>Resident medications.</b>
	<b>(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.</b>
<b>ANALYSIS:</b>	Based on the findings of the investigation, which included my observation and an interview with home manager, Ms. Balina, there is a preponderance of evidence to establish this violation.  Ms. Balina confirmed that staff, Mr. Yurkovich and Ms. Dziedzic both administer medication, however, could not provide an explanation as to where the training verification was.  I observed that both Mr. Yurkovich and Ms. Dziedzic did not have any verification to confirm that they had been trained in the proper handling and administration of medication.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**INVESTIGATION:**

On 08/18/25, I conducted an unscheduled onsite inspection and reviewed the last six months of menus. I observed that the dinner menu for the week of 08/18/25 was not completed.

I interviewed home manager, Christine Balina, and she reported that she is responsible for completing the menus and she would be completing it today and posting it as required. I informed Ms. Balina that the menus are required to be completed one week in advance and posted. Ms. Balina reported that she is aware.

On 09/02/25, I conducted the exit conference with licensee designee, Renee Reynolds, and informed her of the findings of the investigation and the specific rule cited. Ms. Reynolds reported that Ms. Balina is responsible for completion of the menus and it should have been done.

<b>APPLICABLE RULE</b>	
<b>R 400.14313</b>	<b>Resident nutrition.</b>
	<b>(4) Menus of regular diets shall be written at least 1 week in advance and posted. Any change or substitution shall be noted and considered as part of the original menu.</b>
<b>ANALYSIS:</b>	Based on the findings of the investigation, which included my observation and an interview with home manager, Christine Balina, there is a preponderance of evidence to establish this violation.  I observed that the dinner menu for the week of 08/18/25 was not completed and posted as required by these rules,  Ms. Balina admitted that she is responsible for the completion and posting of menus and it will be completed today (08/18/25).
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**INVESTIGATION:**

On 08/18/25, I conducted an unscheduled onsite inspection and reviewed Resident A-C’s record. I observed that Resident B’s funds part II form did not document her monthly cost of care from April 2025 through July 2025.

On 09/02/25, I conducted the exit conference with licensee designee, Renee Reynolds and informed her of the findings of the investigation and the specific rule cited. Ms. Reynolds reported an understanding.

<b>APPLICABLE RULE</b>	
<b>R 400.14315</b>	<b>Handling of resident funds and valuables.</b>
	<b>(3) A licensee shall have a resident's funds and valuables transaction form completed and on file for each resident. A department form shall be used unless prior authorization for a substitute form has been granted, in writing, by the department.</b>
<b>ANALYSIS:</b>	Based on the findings of the investigation, which included my observation, there is a preponderance of evidence to establish this violation.  I observed that Resident B’s funds part II did not document her monthly cost of care from April 2025 through July 2025.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**INVESTIGATION:**

On 08/18/25, I conducted an unscheduled onsite inspection and observed that the front door (an approved means of egress) was equipped with a white plastic child safety doorknob cover, that prevents unobstructed egress.

On 09/02/25, I conducted the exit conference with licensee designee, Renee Reynolds and informed her of the findings of the investigation and the specific rule cited. Ms. Reynolds reported the child safety doorknob cover has been removed.

<b>APPLICABLE RULE</b>	
<b>R 400.14507</b>	<b>Means of egress generally.</b>
	<b>(5) A door that forms a part of a required means of egress shall be not less than 30 inches wide and shall be equipped</b>

	<b>with positive-latching, non-locking-against-egress hardware.</b>
<b>ANALYSIS:</b>	Based on the findings of the investigation, which included my observation, there is a preponderance of evidence to establish this violation.  I observed the front doorknob with a child safety doorknob cover. This device prevents the residents from egress.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**IV. RECOMMENDATION**

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.



Pandrea Robinson  
Licensing Consultant

09/19/25  
Date

Approved By:



09/22/25

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Ardra Hunter  
Area Manager

Date