



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

October 2, 2025

Laura Kujawski
Care And Comfort AFC, LLC
40796 Ruggero St
Clinton Township, MI 48038

RE: License #: AS500418411
Investigation #: 2025A0604020
Care and Comfort AFC Group Home

Dear Ms. Kujawski:

Attached is the Special Investigation Report for the above referenced facility. Due to the severity of the violations, disciplinary action against your license is recommended. You will be notified in writing of the department's action and your options for resolution of this matter.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (248) 972-9136.

Sincerely,

A handwritten signature in cursive script that reads "Kristine Cilluffo".

Kristine Cilluffo, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 West Grand Blvd Ste 9-100
Detroit, MI 48202
(248) 285-1703

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS500418411
Investigation #:	2025A0604020
Complaint Receipt Date:	08/01/2025
Investigation Initiation Date:	08/04/2025
Report Due Date:	08/31/2025
Licensee Name:	Care And Comfort AFC, LLC
Licensee Address:	40796 Ruggero St Clinton Township, MI 48038
Licensee Telephone #:	(517) 455-9900
Administrator:	Laura Kujawski
Licensee Designee:	Laura Kujawski
Name of Facility:	Care and Comfort AFC Group Home
Facility Address:	40796 Ruggero Street Clinton Township, MI 48038
Facility Telephone #:	(586) 372-6116
Original Issuance Date:	08/28/2024
License Status:	REGULAR
Effective Date:	02/28/2025
Expiration Date:	02/27/2027
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Amitkumar "Yogi" Kalasariya has identified himself as owner and licensee of home despite settlement agreement dated 05/14/2024 where he agreed to not act as licensee designee for any new homes for a period of five years.	Yes
Resident A died after falling from bed. Staff falsely claimed to have checked on him and refused CPR despite 911's instructions.	Yes

III. METHODOLOGY

08/01/2025	Special Investigation Intake 2025A0604020
08/04/2025	Special Investigation Initiated - Letter Email to licensee. Requested incident report re: resident death and updated licensee designee/administrator information
08/04/2025	Contact - Document Received Received return email from licensee
08/05/2025	Inspection Completed On-site Completed unannounced onsite investigation. Interviewed Staff, Kristi Aikins
08/05/2025	Contact - Document Received Received copy of incident report by email from licensee
08/08/2025	Contact - Document Sent Email to Complainant re: additional information
08/09/2025	Contact - Document Received Received return email from Complainant. Received link with texts messages, police body camera videos, copies of checks made out to Caring Professionals, and transcript/recording of 911 call.
08/11/2025	Contact - Document Sent Requested employee and resident records from licensee
08/11/2025	Contact - Document Received Received email from Complainant with link to documents
08/11/2025	Contact - Document Sent Email to Complainant re: documents

08/12/2025	Contact - Document Received Email received from Akanksha Nakum
08/12/2025	Contact - Document Sent Email to Akanksha Nakum
08/12/2025	Contact - Document Sent Email to Complainant
08/12/2025	Contact - Telephone call received TC from Amitkumar Kalasariya while conducting onsite investigation at Caring Professionals AFC Home (AS500408403)
08/13/2025	Contact - Document Sent Emailed Technical Assistance manual with DNR/CPR information to licensee
08/13/2025	Contact - Document Sent Email to licensee
08/13/2025	Contact - Telephone call received Received text and message from Laura Kujawski. Returned call
08/14/2025	Contact - Telephone call received TC and text messages from Amitkumar Kalasariya
08/15/2025	Contact - Document Received Received resident records by email from Laura Kujawski
08/19/2025	Contact - Document Received Received resident and employee records from licensee
08/20/2025	Contact- Document Sent Email to licensee re: records
08/20/2025	Contact- Document Sent Email to Complainant
08/20/2025	Contact- Document Received Email from Complainant
09/30/2025	Contact- Telephone call made TC to Staff, Erika Mason

09/30/2025	Exit Conference Left message for licensee designee, Laura Kujawski, and sent email.
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ALLEGATION:

Amitkumar “Yogi” Kalasariya has identified himself as owner and licensee of home despite settlement agreement dated 05/14/2024 where he agreed to not act as licensee designee for any new homes for a period of five years.

INVESTIGATION:

I received a complaint regarding the Care and Comfort AFC Group home on 08/01/2025. The Complainant alleged that an agreement was entered for care of Resident A with "Caring Professionals AFC on 04/18/2025. After Resident A’s questionable death on 05/28/2025 at this location, Complainant found out the license for "Caring Professionals AFC" had been revoked 08/27/2024. The contract was entered with Amitkumar Kalasariya who at the time presented himself as the owner and the licensee of this location. It was discovered that Amitkumar Kalasariya had a ruling against him from department not to be the licensee. Amitkumar Kalasariya fraudulently identified himself as owner/licensee. Staff, Erica Mason made false statements regarding Resident A’s care and her unwillingness to perform life-saving measures per the 911 call. On 05/28/2025 at 7:40 am, Amitkumar Kalasariya contacted family telling them Resident A had peacefully died during the night. It was found out later that he had fallen out of bed, got his head caught between his bed and the bed guard, resulting in position asphyxia per the medical examiner. After further investigation and contacting FOIA, it was discovered that Resident A had been dead for at least three to four hours, as rigor mortis had set in. Erika Mason claimed she checked on him at 6:00 a.m. and again at 7:00 a.m. After reviewing the 911 call, Erica did nothing and seemed unable to attempt to save him, stating "I don't know if I can do CPR, that's not in the plan". The 911 dispatcher was encouraging her to attempt CPR as soon as possible to try to save him but she refused. Police arrived five minutes later, and attempted CPR to no avail. Resident A was already dead and according to the body-cam footage, the police were heard commenting "He's been dead for awhile", which is in direct conflict with Erica's story. Complainant can provide full 911 call and body-cam footage from the Clinton Township Police.

A settlement agreement for Caring Professionals LLC was signed by Amitkumar Kalasariya on 05/14/2024 after a recommendation for refusal to renew the license for Caring Professionals AFC Home 2 (AS500412987). The terms of the settlement agreement were as follows:

On or about November 27, 2023, the Bureau of Community and Health Systems (Bureau) issued a Notice of Intent to Refuse to Renew License to operate an adult foster care small group home license known as Caring Professionals AFC Home 2.

In settlement of all issues raised in that Notice of Intent to Refuse to Renew License, the undersigned parties hereby agree:

1) Caring Professionals LLC does not contest the allegations set forth in the Notice of Intent to Refuse to Renew License and agrees that the Bureau may treat the allegations of fact and law as true, which finding shall have the same force and effect for purposes of this settlement agreement as if evidence and argument were presented in support of the allegations.

2) Caring Professionals LLC is not admitting the truth of the allegations but is agreeing that the Bureau may treat the allegations as true for purposes of resolution of the Notice of Intent to Refuse to Renew License and any future administrative or disciplinary matter concerning adult foster care small group home license #AS500412987.

3) Caring Professionals LLC understands that license #AS500412987 will be administratively closed, effective either four (4) months from the date of execution of this agreement by the Bureau or upon the issuance of a new license for Care and Comfort AFC, LLC, whichever happens first. Caring Professionals LLC agrees to not apply for a license for an adult foster care facility licensed under the Adult Foster Care Facility Licensing Act for a period of five (5) years.

4) This agreement for license #AS500412987 does not impact Caring Professional LLC's ability to renew its currently licensed home, license # AS500408403.

5) This agreement for license #AS500412987 does not impact the current pending application with licensee designee, Caring Professionals BH, LLC, for the property located at 240 Applewood Lane, Bloomfield Twp., MI 48302.

6) Amitkumar Kalasariya agrees to not be the licensee designee for any other new applications for a period of five (5) years, but this agreement for license #AS500412987 does not impact the current pending application for the property located at 240 Applewood Lane, Bloomfield Twp., MI 48302.

7) Caring Professionals LLC understands that it is waiving its right to appeal the Notice of Intent to Refuse to Renew License, and a hearing will not be held in this matter.

8) Caring Professionals LLC understands that pursuant to MCL 400.731(1), operating an adult foster care facility without a license is a violation of the Adult Foster Care Licensing Act and a misdemeanor, punishable by imprisonment up to 1 year or a fine of not more than \$1,000, or both.

On 08/05/2025, I completed an unannounced onsite investigation. I interviewed Staff, Kristi Aikins. When I arrived at the home, Ms. Aikins stated that she would call "Yogi" which is name staff use for Amitkumar Kalasariya. Ms. Aikins called Mr. Kalasariya who answered on speaker phone. Ms. Aikins also attempted to call current Licensee Designee/Administrator, Laura Kujawski, during onsite investigation, however, she did

not answer. Ms. Aikins indicated that Laura is registered nurse. She stated that Yogi is the owner of the home and does physical therapy with residents. She indicated that Yogi visits the home every day to do general checks on residents.

On 08/09/2025, I received email from Complainant with texts messages, police body camera videos, copies of checks made out to Caring Professionals, and transcript/recording of 911 call.

On 08/09/2025, I received copies of three checks from Complainant. Checks were made out to Caring Professionals, not Care and Comfort AFC, LLC, for Resident A's care on 04/14/2025, 04/20/2025 and 05/02/2025.

On 08/09/2025, I received copies of two text messages from Complainant. The texts are from Lisa Cooney at Next Step Seniors who provided referral to Care and Comfort AFC Home for Resident A's care. Ms. Cooney set up a visit to view home with "Yogi".

On 08/12/2025, I interviewed Amitkumar Kalasariya by phone. Mr. Kalasariya denied continuing to act as licensee designee/administrator for the Care and Comfort AFC Home. He stated that he only provides physical therapy at the home.

On 08/13/2025, I interviewed licensee designee, Laura Kujawski, by phone. She stated that she resigned from the position months ago, however, is still employed by licensee and is doing job until she is replaced. She stated that the home is owned by "Rick" and "Yogi". Rick is the investor and is responsible for things such as payroll. Yogi is responsible for resident care and is an active participant in the home. Staff can call him for guidance. He is also responsible for screening new hires and has relationships with residents' families. She stated that he is not responsible for monitoring medications. She indicated that he does not only do physical therapy at home as reported. Ms. Kujawski expressed concern regarding owner's ability to manage the home appropriately.

On 08/14/2025, I received employee records by text from Amitkumar Kalasariya for an open special investigation at the Caring Professionals AFC Home (AS500408403). The licensee for the home is Caring Professionals LLC and Mr. Kalasariya is currently the licensee designee/administrator for this home. Mr. Kalasariya provided a workforce background check for Staff, Marie Besse, for the Care and Comfort AFC Group Home dated 03/27/2025. Caring Professionals LLC should not have access to Care and Comfort AFC Group Home's employee records. On 08/14/2025, I spoke to Mr. Kalasariya by phone and he again denied being involved in Care and Comfort AFC Home and stated that clearance was located at the Caring Professionals AFC Home.

On 08/20/2025, I received email from Complainant. The Complainant indicated that they have never met or heard of current licensee designee, Laura Kujawski.

On 09/30/2025, I interviewed Staff, Erika Mason, by phone. She indicated that she has worked at the Care and Comfort AFC Group Home for about three years. She

confirmed that her boss is Laura, however, could not remember her name. She stated that she heard of “Yogi” when she started at home, however, he does not have any involvement now.

On 10/2/2025, according to BITS, Laura Kujawski is currently documented as the licensee designee and administrator.

APPLICABLE RULE	
R 400.14201	Qualifications of administrator, direct care staff, licensee, and members of household; provision of names of employee, volunteer, or member of household on parole or probation or convicted of felony; food service staff.
	<p>(9) A licensee and the administrator shall possess all of the following qualifications:</p> <p style="padding-left: 40px;">(a) Be suitable to meet the physical, emotional, social, and intellectual needs of each resident.</p> <p style="padding-left: 40px;">(b) Be capable of appropriately handling emergency situations.</p> <p style="padding-left: 40px;">(c) Be capable of assuring program planning, development, and implementation of services to residents consistent with the home's program statement and in accordance with the resident's assessment plan and care agreement.</p>
ANALYSIS:	<p>Caring Professionals LLC and Amikumar “Yogi” Kalasariya have continued to operate the Care and Comfort AFC Group Home. The Care and Comfort AFC Group Home was previously licensed as Caring Professionals AFC Home 2 (AS500412987). Caring Professionals LLC was the licensee for the home and Mr. Kalasariya acted as the licensee designee and administrator. A settlement agreement for Caring Professionals LLC was signed by Amitkumar Kalasariya on 05/14/2024 after a recommendation for refusal to renew the license for Caring Professionals AFC Home 2 was made. Amitkumar Kalasariya agreed to not be the licensee designee for any new applications for a period of five (5) years, with the exception of license #AS500412987, which was a pending application for the property located at 240 Applewood Lane, Bloomfield Twp., MI 48302. Caring Professionals agreed that the license would be administratively closed and Caring Professionals LLC agreed to not apply for a license for an adult foster care facility licensed under the Adult Foster Care Facility Licensing Act for a period of five (5) years. Care And Comfort AFC, LLC became licensed at the address on 08/28/2024, with Laura Kujawski acting as the licensee designee and administrator.</p>

	<p>On 08/12/2025, Mr. Kalasariya denied continued involvement with the Care and Comfort AFC Home and stated that he only provides physical therapy.</p> <p>On 08/05/2025, I completed an unannounced onsite investigation and staff, Kristi Aikins, contacted Mr. Kalasariya upon my arrival. She indicated that he visits daily to check on residents. Mr. Kalasariya has also been reported to have provided notification to family when Resident A passed away and was identified as contact person when Resident A was referred to the home.</p> <p>On 08/09/2025, I received copies of three checks from Complainant. Checks were made out to Caring Professionals, not Care and Comfort AFC, LLC, for Resident A's care on 04/14/2025, 04/20/2025 and 05/02/2025. On 08/13/2025, I interviewed licensee designee, Laura Kujawski. She stated that the home is owned by "Rick" and "Yogi". Rick is the investor and is responsible for things such as payroll. Yogi is responsible for resident care and is an active participant in the home. Staff can call him for guidance. He is also responsible for screening new hires and has relationships with residents' families. In addition, on 08/14/2025 Mr. Kalasariya provided a workforce background check for staff at the Care and Comfort AFC Home.</p>
CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION:

Resident A died after falling from bed. Staff falsely claimed to have checked on him and refused CPR despite 911's instructions.

INVESTIGATION:

On 08/05/2025, I interviewed staff, Kristi Aikins, at the home. She stated she was not working during shift when Resident A passed away. She was working 8:00 am -4:00 pm shift and when she arrived, police and everyone were at home. She was not aware of the police expressing any concerns regarding Resident A's death. Ms. Aikins stated that residents are checked every two hours during the day and every hour during the night. Ms. Aikins stated that she is trained in CPR/First Aid. She did not know if Resident A had a DNR order. Ms. Aikins indicated that she would defer to manager to see if resident had a DNR or check the resident's book to see if there was a DNR.

On 08/09/2025, I received a copy of the recording and transcript of 911 call from Complainant by email. The following is transcript of the 911 call:

911 What's your emergency?

Erica: I'm at work and one of my clients fell off the bed. And I need assistance 911. I was on my daily rounds and he was on the floor.

Dispatch: Ok what's the address there?

Erica: The address is 40796 Ruggero Street.

Dispatch: And how old is the male?

Erica: And I think he's about 80 something.

Dispatch: Ok, and are you like his caregiver?

Erica: Yeah I'm the caregiver, I'm the night caregiver. I was doing my nightly rounds and I was wondering if I could change him and get him together for the morning. And he's on the floor.

Dispatch: Is this like a group home?

Erica: Like assisted living but a home.

Dispatch: Ok, is he injured or just needs help getting up?

Erica: He's not blue, he's just not moving.

Dispatch: ok, is he breathing?

Erica: I don't think so.

Dispatch: So you don't think he's breathing?

Erica: No, I called his name he's not responding to me.

Dispatch: ok, do you want to start CPR?

Erica: Umm, I'm not even sure we can do CPR on these clients. Cause it's not in the plan or anything.

Dispatch: He what?

Erica: I'm not sure I don't think we can do CPR because it's not in our plan. It's just set up to call 911.

Dispatch: Ok, we have help on the way, what do you mean you don't know if you can do CPR, like

Erica: (Talking to Someone in background) Am I allowed to do CPR?

Inaudible conversation in background

Dispatch: Hello, are you talking to me?

Erica: One second, one second. (Talking to someone in background) Am I able to do CPR?

Inaudible answer

Erica: Like I don't want to move him because he's like stuck in between like the bed and if I move him he's going to drop to the floor kinda like

Dispatch: Ok, well if he's not breathing he's not going to care that he fell to the floor. So I can talk you through CPR.

Erica: I'm on the phone to see if I'm able to do CPR.

Dispatch: Ok, so let me know when they tell you if you can because you have to do it as quickly as possible.

Pause

Dispatch: Is he cold to the touch?

Erica: (long pause)...inaudible.....Ma'am, see the bed that he has is not a hospital bed, it's like a regular house bed, and he got like you know the rails that push in the groove of the bed, I can't even like move, he's like, I can't even move the rails.

Dispatch: Ok, so we can't get him to the floor or on the bed?

Erica: That's what I'm saying, he's on the floor, but his head was like in the rail, he like stuck in the rail, and like the rail is really pushed out and it's like he's like heavy so I can't even pull him the rail.

Dispatch: Ok, you're unable to move him

Erica: Yeah, I cannot move him at all, like I'm trying it's just like I can't

Dispatch: Can you verify for sure that his chest is not going up and down and he's not breathing?

Erica: No, it don't look like it to me

Dispatch: No, it doesn't look like it, ok. What was your name?

Erica: Erica, he's not blue or anything.

Dispatch: Is he cold?

Erica: Ahhh yes, he cold.

Dispatch: He's cold, ok. What did you say your name is Erica?

Erica: Yes

Dispatch: And your phone number?

Erica: 313 721-4537

Dispatch: ok, go ahead and unlock the front door for me, are there any animals in the home?

Erica: No, there's not

Dispatch: ok, and then just wait by the front door, they will be there shortly.

Erica: Ok

On 08/09/2025, I received four police body camera videos from Complainant by email. The videos show Clinton Township police and fire department responding to 911 call. Staff informs officers that she found Resident A in rail when she was doing her rounds and did not observe fall. She indicates that she is working alone. Officers move Resident A on floor and begin chest compressions. Fire department is also seen responding to call. The responders indicate in video that Resident A's jaw is stiffening which is a sign that rigor mortis is setting in. They also indicate that Resident A is cold.

On 08/13/2025, I interviewed licensee designee, Laura Kujawski, by phone. She stated that the standard is for staff to check on residents every two hours unless they have a do not disturb preference in their care plan, in which they will check on them less. Ms. Kujawski did not know if Resident A had a do not disturb preference and indicated that she would provide copy of his assessment plan. Ms. Kujawski was unsure if Resident A had a DNR order in place.

On 08/19/2025, I received resident records for Resident A from licensee by email. Records included resident care agreement, resident assessment plan, health care appraisal, physician authorization for assistive devices, incident reports and health care chronological. Resident A had a current health care appraisal dated 04/18/2025. The

health care appraisal indicates that Resident A uses a wheelchair. Note states that he is non-ambulatory and depends on a wheelchair.

On 08/19/2025, I received copy of Resident A's assessment plan dated 04/18/2025 from licensee. The plan is signed by Laura Kujawski and Resident A's designated representative. The plan indicates that Resident A is non-ambulatory and requires a one person assist. Assistive devices listed in Resident A's assessment plan include wheelchair, side rail and walker.

On 08/19/2025, I received copy of physician authorization for Resident A's assistive devices dated 04/24/2025. Order is for front wheel walker, standard wheelchair and half rail. The date on signature line appears to be covered in white out and is typed in underneath.

On 08/19/2025, I received copy of incident report completed by Staff, Erika Mason, on 05/28/2025. The report states, "I was doing my rounds around 7 and (Resident A) fell in between his bed. 911 was called, management was contacted. Family was contacted. CPR was performed. Action taken notes, "The paramedics was called. Management was contacted and family was also contacted.". Laura K. is the only person listed under person(s) notified on incident report. Her name is listed under AFC licensing.

On 08/19/2025, I received copy of staff, Erica Mason's employee records from licensee by email. I received copy of Ms. Mason's application, reference checks, medical/TB test, verification of training, current CPR/First Aid, Workforce Background Check, verification of personnel policies and job description and copy of driver's license. Ms. Mason's employee records indicated that she completed CPR/First Aid training on 06/19/2024 and that training is valid for two years.

On 08/20/2025, I received email from Complainant. The Complainant indicated that Resident A's cause of death was positional asphyxia. Resident A did not have a DNR.

On 08/20/2025, I received email from Akanksha Nakum at Care and Comfort AFC. Ms. Nakum indicated that Resident A did not have a DNR order.

On 09/30/2025, I interviewed staff, Erika Mason, by phone. Ms. Mason indicated that she has worked at the home about three years. Ms. Mason stated that she was doing checks on residents every one to two hours. She stated that Resident A was always trying to get out of bed. Ms. Mason stated that she checked on Resident A that day and told him she would be right back. She indicated that she went to help another resident and then came right back to his room. When she returned, she found Resident A had fallen and rail was not on bottom of bed. Ms. Mason could not give estimate of how much time passed between her checking on Resident A and returning to his room and finding he had fallen. Ms. Mason believed that when she returned to room that Resident A was deceased. Ms. Mason stated that she called 911. She stated that she did not do CPR because she did not believe they are allowed to.

On 09/30/2025, I completed exit conference by phone and email with licensee designee, Laura Kujawski. I left Ms. Kujawski a message and sent email. I informed Ms. Kujawski of my findings and recommendation and requested that she contact me with any questions. I also informed her that I would contact her with any changes and mail a copy of special investigation report once approved.

APPLICABLE RULE	
R 400.14204	Direct care staff; qualifications and training.
	(2) Direct care staff shall possess all of the following qualifications: (b) Be capable of appropriately handling emergency situations.
ANALYSIS:	Staff, Erika Mason, was unaware if she was able to provide CPR in an emergency situation. On 05/28/2025, Staff Erica Mason contacted 911 when Resident A was found to have fallen out of bed and was stuck in the bedrail. A recording and transcript of 911 call was provided to licensing. Ms. Mason informs 911 dispatcher that she is unsure if she is able to do CPR. She states, "Umm, I'm not even sure we can do CPR on these clients. Cause it's not in the plan or anything." Ms. Mason can be heard on call speaking to someone else. She then tells dispatcher, "I'm on the phone to see if I'm able to do CPR." Resident A did not have a DNR order.
CONCLUSION:	VIOLATION ESTABLISHED

APPLICABLE RULE	
R 400.14204	Direct care staff; qualifications and training.
	(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) First aid. (c) Cardiopulmonary resuscitation.
ANALYSIS:	Licensee provided verification that staff, Ericka Mason, had current First Aid/CPR Training. Ms. Mason completed CPR/First Aid training on 06/19/2024 and training is valid for two years.
CONCLUSION:	VIOLATION NOT ESTABLISHED

APPLICABLE RULE	
R 400.14305	Resident protection.
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	On 05/28/2025, Resident A passed away at the home due to positional asphyxia. Staff, Erika Mason, indicated that she was checking on residents every one to two hours. Ms. Mason stated that she checked on Resident A that day and told him she would be right back. She went to help another resident and then came right back to his room. When she returned, she found Resident A had fallen and the rail was not on bottom of bed. Ms. Mason could not give an estimate of how much time passed between her checking on Resident A and returning to his room and finding he had fallen. Ms. Mason contacted 911, however, did not perform CPR as instructed. She stated that she did not believe they were allowed to and stated that she believed Resident A was already deceased. The length of time Resident A was deceased when found is unknown. The responders indicate in body camera video that Resident A's jaw is stiffening which is a sign that rigor mortis is setting in (which can occur in two-hour period). They also indicate that Resident A is cold.
CONCLUSION:	VIOLATION ESTABLISHED

APPLICABLE RULE	
R 400.14316	Resident records.
	(1) A licensee shall complete, and maintain in the home, a separate record for each resident and shall provide record information as required by the department. A resident record shall include, at a minimum, all of the following information: (d) Health care information, including all of the following: (v) Instructions for emergency care and advanced medical directives.

ANALYSIS:	Staff, Erika Mason, was unaware if she was able to provide CPR to Resident A. On 05/28/2025, Staff Erica Mason contacted 911 when Resident A was found to have fallen out of bed and was stuck in bedrail. A recording and transcript of 911 call was provided to licensing. Ms. Mason informs 911 dispatcher that she is unsure if she is able to do CPR. Resident A did not have a DNR order.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

I recommend revocation of the license.

Kristine Cilluffo

09/30/2025

Kristine Cilluffo
Licensing Consultant

Date

Approved By:

Denise Y. Nunn

10/02/2025

Denise Y. Nunn
Area Manager

Date