GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

November 24, 2025

Sharon Cuddington
Trinity Continuing Care Services, Suite 200
20555 Victor Parkway
Livonia, MI 48152

RE: License #:	AL610261127
Investigation #:	2025A0356060
	Sanctuary at the Oaks #1

Dear Ms. Cuddington:

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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

Please review the enclosed documentation for accuracy and contact me with any questions. If I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

Elizabeth Elliott

Elizabeth Elliott, Licensing Consultant
Bureau of Community and Health Systems
350 Ottawa, N.W., Grand Rapids, MI 49503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL610261127
Investigation #:	2025A0356060
Complaint Receipt Date:	09/26/2025
Investigation Initiation Date:	09/26/2025
Report Due Date:	11/25/2025
Licensee Name:	Trinity Continuing Care Services
LicenseeAddress:	Suite 200 20555 Victor Parkway Livonia, MI 48152
Licensee Telephone #:	(810) 989-7492
Administrator:	Sharon Cuddington
Licensee Designee:	Julie Treakle
Name of Facility:	Sanctuary at the Oaks #1
Facility Address:	1740 Village Drive, 1st Floor Muskegon, MI 49442-4282
Facility Telephone #:	(231) 672-2700
Original Issuance Date:	04/21/2005
License Status:	REGULAR
Effective Date:	10/26/2025
Expiration Date:	10/25/2027
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED, ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A's assessed needs were not met at the facility.	Yes
The licensee failed to protect Resident A from Resident B.	No
Additional Finding	Yes

III. METHODOLOGY

09/26/2025	Special Investigation Intake 2025A0356060
09/26/2025	Special Investigation Initiated - Telephone Julie Treakle, administrator.
09/26/2025	APS Referral Stephanie Kindle, Muskegon Co. DHHS, APS worker.
09/29/2025	Contact - Telephone call made J. Treakle, Administrator.
09/30/2025	Contact - Telephone call made Dawn Evans, nurse manager, Lisa Edlund, Nurse consultant Trinity Health, Julie Winkle, stand in administrator in Julie Treakle's absence.
09/30/2025	Contact - Document Sent Email, Sharon Cuddington, LD.
10/01/2025	Contact - Document Received Facility documents.
10/06/2025	Contact - Telephone call made Katie Schlacke, Trinity Health.
10/06/2025	Contact - Document Received Facility documents
10/09/2025	Inspection Completed On-site
10/09/2025	Contact - Face to Face Julie Treakle, administrator, Sharon Cuddington, Licensee Designee.

10/27/2025	Contact - Document Received Stephanie Kindle, APS
11/04/2025	Contact - Telephone call made Katie Schlake, Trinity Health.
11/10/2025	Contact - Document Received S. Kindle, APS.
11/12/2025	Contact - Telephone call made Relative #1
11/14/2025	Contact - Face to Face Unannounced inspection at the facility. Interviews with Julie Treakle, administrator, DCW's Anne Donohue, Cassie Keeler, Keyonda Sumlin.
11/17/2025	Contact - Telephone call made Meredith Heinlein NP, Angela Hicks, former nurse at facility.
11/17/2025	Contact - Document Received Stephanie Kindle, APS
11/18/2025	Contact - Telephone call made Relative #2, Dawn Evans, facility nurse.
11/18/2025	Contact - Document Received Facility documents.
11/24/2025	Exit Conference Sharon Cuddington, Licensee designee.

ALLEGATION: Resident A's assessed needs were not met at the facility.

INVESTIGATION: On 09/26/2025, I received a LARA-BCHS (Licensing and Regulatory Affairs, Bureau of Community Health Systems) online complaint. The complainant reported Resident A was not being fed at the facility and that she lost 30 lbs. in a short amount of time.

On 09/26/2025, another complaint came from Adult Protective Services, Muskegon County DHHS (Department of Health and Human Services). The complainant reported that Resident A lost 30 lbs. in approximately 4-6 weeks. Resident A is very thin and is sleeping through meals. The complainant reported that staff at the facility do not wake Resident A up for meals. This is a memory care facility.

On 09/26/2025, I reviewed the complaint allegations with Stephanie Kindle, Muskegon County DHHS, Adult Protective Services (APS) worker. Ms. Kindle is investigating this allegation.

On 10/09/2025, I conducted an inspection at the facility and interviewed Julie Treakle, administrator and Sharon Cuddington, Licensee Designee. Ms. Cuddington stated Resident A was admitted to the facility 03/18/2025 and discharged on 09/19/2025 and confirmed that Resident A lost weight while at the facility. Ms. Cuddington and Ms. Treakle stated Resident A was under a doctor's care and her weight was monitored by Meredith Heinlein, NP (nurse practitioner). Ms. Heinlein ordered nutritional supplements that family were required to supply. Staff gave the supplement to Resident A but sometimes she refused.

On 10/09/2025, I received and reviewed Resident A's weight record dated 03/18/2025 through 09/09/2025. The weight record documented the following weights:

- 03/18/2025-144
- 04/09/2025-139.2
- 05/05/2025-130.4
- There is no weight documented for 06/2025
- 07/07/2025-139.6
- 08/21/2025-133.6
- 09/09/2025-127.8

The weight record documented a weight loss of 8.8lbs. from April to May 2025, a weight gain of 9.2lbs from May to July with no June 2025 weight and a weight loss of 6lbs from July to August 2025 and another 6lbs. weight loss from August to September 2025. It is noted that this is a 16.2lb weight total loss over a 6-month period with a vast amount of up and down weights in between.

Resident A's Health Care Appraisal dated 03/05/2025, signed by Dr. Byron Varnado, MD documented Resident A was to be given a regular diet.

Resident A's Assisted Living assessment plan dated 03/17/2025, documented staff were to cut up Resident A's food. It also noted Resident A needed to be escorted to meals and required assistance setting up her meal. It noted Resident A likes finger foods, sandwiches, cranberry juice, apple juice.

Resident A's Assessment plan for AFC residents dated 03/17/2025 under eating/feeding, documented Resident A required help and documented 'set up' for the help Resident A required.

On 11/12/2025, I interviewed Relative #1 via telephone. Relative #1 stated Resident A had a 30 lb. weight loss in a short period of time. Relative #1 stated when she asked facility staff about it, they told her that Resident A is up much of the night and sleeps a lot during the day, so they do not wake Resident A up for meals if she is

sleeping. Relative #1 stated other staff told her they did not know Resident A had lost weight or that they did not work during meal time hours so they would not have fed Resident A. Relative #1 stated staff were supposed to get Resident A up for every meal but staff failed to get Resident A up for meals resulting in a sizeable weight loss.

On 11/14/2025, I conducted an unannounced inspection at the facility and interviewed Ms. Treakle (again). Ms. Treakle stated Resident A's weight was a concern, they were aware of her weight loss, and staff were getting Resident A up to eat. If she did not want to get up, staff were not forcing her to wake up and fed her later outside of regular mealtime hours.

On 11/14/2025, I interviewed DCW's (direct care workers) Anne Donohue, Keyonda Sumlin and Cassie Keeler in the dining room at the facility. Ms. Donohue and Ms. Sumlin stated they fed Resident A, they would wake her up if she was sleeping and take her to the dining room. Ms. Donohue stated Resident A ate little and seemed as though she "forgot how to eat." Ms. Keeler stated she did not always work on this floor of the facility but whenever she did, she woke Resident A up and fed her. Ms. Keeler stated she noticed "a bit" of weight loss with Resident A. The DCW's stated if Resident A did not eat a full meal in the dining room, they kept food, cut up and ready to feed Resident A as she would take it. Ms. Donohue stated there was nothing documented that said staff needed to sit and feed Resident A.

On 11/17/2025, I interviewed Meredith Heinlein, nurse practitioner, Trinity Health Geriatrics via telephone. Ms. Heinlein stated Resident A was losing weight rapidly and was down 10 lbs. in one month. Ms. Heinlein stated weight loss for a patient with Alzheimer's dementia as Resident A had was not out of the ordinary however, no one from the facility reported the weight loss to her, Relative #2 was the one who reported it to Ms. Heinlein. Ms. Heinlein stated it was mid/late July 2025, possibly early August 2025, that Resident A's relatives contacted her office and asked Ms. Heinlein to see Resident A as it appeared as though she had noticeably lost weight. Ms. Heinlein brought a scale to the facility. She weighed Resident A and Resident A had lost 10 lbs. Ms. Heinlein stated she questioned staff about feeding Resident A and they told Ms. Heinlein that they would allow Resident A to sleep during the day because she was up all night. Ms. Heinlein stated staff told her they tried to feed Resident A, but if she was sleeping, they did not wake her up but that she gets dinner because she was awake at that time of the day. Ms. Heinlein stated she found staff, "very lackadaisical" about the subject. Ms. Heinlein stated she wrote orders that Resident A attend all meals and that staff document the amount Resident A eats at each meal. Ms. Heinlein stated Resident A's family was also bringing nutritional supplements into the facility for staff to give Resident A. Ms. Heinlein stated Resident A had a fast progressive dementia, and the disease progress was not going to stop so all that could be done was to care for Resident A the best way possible and she (Ms. Heinlein) stated Resident A's care needs quickly advanced and exceeded the facility's ability to handle them.

On 11/17/2025, I interviewed Angela Hicks, (former) facility RN via telephone. Ms. Hicks acknowledged that Resident A lost weight while at the facility. Ms. Hicks stated staff encouraged Resident A to eat. She walked constantly and never stopped moving so it was a challenge to get her to sit and eat a meal. Ms. Hicks stated staff offered her food when she woke up. Staff walked with Resident A and tried to get her into the dining room for meals. Ms. Hicks stated Resident A's meals were stored in the refrigerator in the dining room, so staff had quick access to them, and nutritional supplements were implemented. Ms. Hicks stated she did not report Resident A's weight loss to Resident A's doctor.

On 11/18/2025, I interviewed Dawn Evans, facility nurse via telephone. Ms. Evans stated she was not working at the facility for very long while Resident A was there and stated she did not notice Resident A's weight loss or report Resident A's weight loss to anyone, including the facility doctor or NP, Meredith Heinlein.

On 11/18/2025, I interviewed Relative #2 via telephone. Relative #2 stated Ms. Heinlein saw Resident A in July and August 2025, but it was Relative #3 that told Relative #2 that Resident A appeared thin. Relative #2 stated she reviewed Resident A's My Chart, online medical records and noted a significant weight loss from July to August 2025 and contacted Dr. Dills office and reported the weight loss to Ms. Heinlein, NP. Relative #2 stated she discussed Resident A's weight loss with Ms. Treakle and Julie Winkle, Trinity Health corporate office administrator, and they reportedly did not notice any weight loss. Relative #2 stated she asked Ms. Treakle and Ms. Winkle if Resident A was eating and Relative #2 stated Ms. Treakle told her it was not their responsibility to make sure residents are eating. Relative #2 stated there are no records to show Resident A's intake of food and staff are not waking Resident A up to eat because it is easier to put food in front of her when she wakes up on her own and staff do not feed Resident A to make sure she is eating.

On 11/18/2025, I received and reviewed Resident A's after visit summary from Trinity Health dated 07/22/2025, which documented Resident A saw M. Heinlein, NP and Resident A's weight was 151lbs. The next after visit summary from Trinity Health dated 08/18/2025, documented Resident A saw M. Heinlein, NP and Resident A's weight is documented as 128 lbs. The Trinity after visit summary documented Resident A's weight loss as 23lbs. in one month.

On 11/18/2025, I received and reviewed an excel spreadsheet from the facility documenting Resident A's meal intake amounts beginning 08/21/2025 and ending on 09/19/2025. The meal intake amounts showed Resident A eating between 1 and 3 meals each day and the amount of food intake ranging between 0% intake and 100% intake. There are no dates documented that show Resident A did not have any food intake all day.

On 11/24/2025, I conducted an exit conference with Sharon Cuddington, Licensee Designee via telephone. Ms. Cuddington stated they can only go by the weight log they keep at the facility as they do not have access to Resident A's My Chart

findings when she is seen by her primary care physician. Ms. Cuddington stated they were not notified by anyone regarding Resident A's weight from the doctor's office. Ms. Cuddington stated Resident A lost 16.2 lbs. over a 6-month period which averages approximately 2.7 lbs. a month, which would not be uncommon for a resident in advanced stage Alzheimer's. Ms. Cuddington stated she also questions the My Chart weight as the weight documented in July 2025 on My Chart was more than her weight when she moved into the facility in March 2025. Ms. Cuddington will review this report and submit a corrective action plan.

APPLICABLE RULE	
R 400.671	**Resident care.**
	(4) A licensee shall provide supervision, protection, and personal care as specified in a resident's assessment plan. A hospice service plan, do-not resuscitate order, or any other advance directive must be included as an addendum to the resident assessment and maintained with the assessment plan in the resident's record.
ANALYSIS:	The complainant reported that staff at the facility do not wake Resident A up for meals and Resident A lost 30 lbs. in approximately 4-6 weeks. Resident A's weight chart documented a 16.2lb weight loss over a 6-month period. The Trinity Health medical chart documented a weight loss of 23lbs in one month from July to August 2025. A review of Resident A's assessment plan documented Resident A had a regular diet, required food to be cut up, required an escort to meals and assistance with meal set up. Relative #1 and #2 stated Resident A had a significant weight loss in a short period of time. Relative #1 stated staff reported Resident A is up much of the night and sleeps a lot during the day, so they do not wake Resident A up for meals if she is sleeping. Ms. Donohue, Ms. Sumlin and Ms. Keeler stated they fed Resident A, they woke her up if she was sleeping and took her to the dining room. Ms. Heinlein stated weight loss for a patient with Alzheimer's dementia is not out of the ordinary; however, no one from the

	facility reported the weight loss to her and Resident A was down 10 lbs. in a month. Ms. Heinlein stated staff reported they allowed Resident A to sleep during the day, staff tried to feed Resident A, but if she was sleeping, they did not wake her up. Ms. Heinlein reported she found staff, “very lackadaisical” about the subject. Ms. Hicks and Ms. Evans acknowledged they did not report Resident A’s weight loss to medical professionals. The meal intake document showed Resident A ate between 1 and 3 meals each day, and there are no dates documented that show Resident A did not have some food intake all day. Based on investigative findings, there is a preponderance of evidence to show that Resident A sustained some weight loss while at the facility and the weight loss was not reported to medical professionals by staff. In addition, staff were not making sure Resident A was escorted to each meal every day as the assessment plan documented and therefore, a violation of this applicable rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: The licensee failed to protect Resident A from Resident B.

INVESTIGATION: On 09/26/2025, I received a LARA-BCHS (Licensing and Regulatory Affairs, Bureau of Community Health Systems) online complaint. The complainant reported Resident A got an eviction from the facility because a complaint was lodged that someone had assaulted her. The complainant reported that no one will take Resident A in a new facility due to this “eviction” and currently Resident A is in Trinity Health hospital with nowhere to be discharged to. The complainant reported Resident A was assaulted by Resident B in this facility and no one at the facility did anything about it.

On 09/26/2025, another complaint came from Adult Protective Services, Muskegon County DHHS (Department of Health and Human Services). The complainant reported Resident A was “severely” beat up by another resident several times on different occasions. Resident A suffered a bloody lip, bloody nose, a large mark on her chest and a rip down the middle of her shirt and no one at the facility did anything about it and Resident B, being the aggressor, did not get evicted.

On 09/30/2025, I interviewed Dawn Evans, facility nurse, Lisa Edlund, nurse consultant from Trinity Health and Julie Winkle, stand in administrator from corporate

office via telephone. Ms. Edlund stated on 08/22/2025, there was one physical altercation between Resident A and B, there were no other physical altercations that occurred between the two residents prior to or after that incident. Ms. Edlund stated the altercation resulted in a 1:1 supervision of Resident B at the facility and both residents being given a 30-day notice, which is not a legal eviction notice. Ms. Edlund stated at this time, both residents are no longer in the facility. Ms. Edlund stated Resident A went to the hospital on 09/19/2025 by physician order, not due to the physical altercation, she did not return, and a discharge has been completed. Ms. Edlund reported Resident A was not appropriate for this unit. She was aggressive with other residents and suffered from advanced, severe dementia. Ms. Edlund stated after the altercation, Resident B had 1:1 supervision and was discharged on 09/29/2025. Ms. Winkle and Ms. Evans supported Ms. Edlund's information.

On 10/09/2025, I conducted an inspection at the facility and interviewed Ms. Treakle and Ms. Cuddington. Ms. Cuddington and Ms. Treakle stated Resident A & B had one physical altercation only. Resident B had 1:1 supervision immediately and both residents were issued a 30-day discharge notice immediately that day. Ms. Treakle and Ms. Cuddington reported that Resident A had 5 separate ER (emergency room) visits since admission on 03/18/2025. Resident A walked around the facility constantly. There were 10 physical and verbal instances of aggression documented for Resident A since admission and hospice resources were given to relatives for consideration. Ms. Treakle and Ms. Cuddington stated Resident A was admitted to the facility on 03/18/2025 and her first documented behavior was on 03/22/2025, when she hit and kicked staff while they were attempting to change her brief. Ms. Treakle stated this was the only physical altercation between Resident A & B but Resident B had been verbal with Resident A prior to the physical altercation. Ms. Treakle stated Ms. Heinlein, NP followed-up after the physical altercation occurred, either that day (Friday) or the following Monday. Ms. Treakle and Ms. Cuddington concurred with the information provided by Ms. Edlund, Ms. Evans and Ms. Winkle on 09/30/2025.

On 10/09/2025, I reviewed Resident A's assessment plan for AFC residents, dated 03/17/2025. This documented Resident A does not control aggressive behavior and 'redirecting helps.'

On 10/09/2025, I reviewed Resident B's assessment plan for AFC residents, dated 05/09/2025 and 07/24/2025. This documented that Resident B controls aggressive behavior.

On 10/09/2025, I reviewed the IR (Incident Report) dated 08/21/2025 at 9:20p.m. The employee was Zaria Gray. The IR documented the following information: '*Entered the apartment and an altercation took place. Zaria Gray, caregiver, heard the altercation and witnessed (Resident B) being aggressive towards (Resident A) resulting in injury. Residents were observed scratching and hitting. (Resident B) grabbed and tore (Resident A's) shirt and then they both fell to the ground. Zaria*

Gray was able to separate (Resident's A&B). Zaria called LaTonya, nurse supervisor, at 9:45p.m. and entered voice report. Resident separated and assessed for injuries. (Resident A) noted with scratch on lip and some bruising on torso. 1:1 supervision for (Resident B) for the next 30 days and issued notification of 30 day discharge notice due to aggressive behavior. Notified Meredith Heinlein, PA and Dr. Muhaskick (sp) for psych consult. Meredith to see (Resident A) on 08/25/2025. (Relative #1) notified on 08/21/2025 at 9:48p.m.'

On 10/09/2025, I reviewed an IR dated 08/21/2025, at 9:20p.m., staff Zaria Gray. The IR documented the following information: *'Resident B) was visiting another resident in that residents apartment. (Resident A) entered the apartment and an altercation took place. Zaria Gray, caregiver, heard the altercation and witnessed (Resident B) being aggressive towards (Resident A) resulting in injury. (Resident B) began pushing (Resident A) out of the room, then residents began hitting and scratching. (Resident B) ripped (Resident A's) shirt and they both fell to the ground. Zaria was able to separate (Resident's A&B). Zaria called LaTonya Hall, nurse supervisor at 9:45p.m. and entered voice report. 1:1 supervision for (Resident B) for the next 30 days and issued notification of 30 day discharge notice due to aggressive behavior. Notified Meredith Heinlein, PA and Dr. Muhaskick (sp) for psych consult. Meredith to see (Resident A) on 08/25/2025. Guardian, Dawn Wentworth notified on 08/22/2025 at 3:45p.m.'*

On 11/12/2025, I interviewed Relative #1 via telephone. Relative #1 stated Resident A was getting attacked by Resident B. Resident B was stalking Resident A and they never discharged Resident B or kept her from walking the same halls at Resident A. Relative #1 stated she was in the facility and sitting in the piano room when Resident B was pushing another resident in a wheelchair down the hall. Relative #1 stated Resident B went into the resident's room with the wheelchair and Resident A followed behind them into the room. That is when Resident B attacked Resident A. Relative #1 stated Resident B tore Resident A's hair out, ripped her sweatshirt, and bloodied her lip. Relative #1 stated Resident A was sent to the hospital for aggression yet Resident B was allowed to remain in the facility. Relative #1 stated Resident A was ignored while living at this facility and she is not aware of any other times when Resident B attacked Resident A other than this one time. Relative #1 stated Resident A was issued a 30-day discharge notice and she received a copy of this notice from the facility, as Resident A's legal guardian.

On 11/14/2025, I conducted an unannounced inspection at the facility and interviewed Ms. Donohue, Ms. Sumlin and Ms. Keeler. The DCW's stated Resident A had gotten into four altercations with three other residents and one with Ms. Sumlin (DCW) during the time she was at the facility. The DCW's reported that Resident B would say things to Resident A verbally but had never physically attacked Resident A prior to this one physical altercation.

On 11/17/2025, I interviewed Meredith Heinlein, nurse practitioner, Trinity Health Geriatrics via telephone. Ms. Heinlein stated Resident A "invaded people's personal

space”, but Resident B was an “instigator, and she was confrontational”, but she is unaware of any other physical altercations aside from this one.

On 11/17/2025, I interviewed Angela Hicks, (former) facility RN via telephone. Ms. Hicks stated Resident B had dementia and would make “comments” to Resident A verbally but there was never a physical altercation prior to this one event. Ms. Hicks stated the “comments” never rose to the level of verbal abuse, and she (Resident B) would whisper things to other residents about Resident A. Ms. Hicks stated staff intervened immediately. Staff redirected the residents and a 1:1 staff was assigned to Resident B immediately. Ms. Hicks stated both residents were issued a 30-day notice and Resident A was evaluated by nursing staff after the altercation.

On 11/18/2025, I interviewed Relative #2 via telephone. Relative #2 stated Resident B was pushing a resident in a wheelchair to her room and Resident A followed them into the room. There was a staff person present in the room when the physical altercation occurred. Relative #2 stated Resident B threw Resident A to the ground, ripped Resident A’s shirt, tore the shirt almost off Resident A’s body, split her lip, and her chest was covered in welts. Relative #2 stated any time Resident A had a fall or any little issue, they sent Resident A to the ER but for this, the facility refused to send Resident A in for evaluation and treatment. Relative #2 stated there was obvious trauma to Resident A’s body and instead, staff called a facility nurse that conducted an evaluation via telephone and instructed staff not to send Resident A into the ER. Relative #2 stated a 30-day discharge notice was put in writing and given to Relative #1 and prior to the expiration of the 30-day notice, Resident A was hospitalized and at the hospital, placement in a different facility was trying to be secured but the facilities were saying they could not take Resident A without inpatient psychiatric evaluation and the hospital said they could not send Resident A to inpatient psych due to the 30 day “eviction” notice.

Relative #2 stated she questioned the legitimacy of the notes coming from this facility to other possible placements for Resident A because the behaviors Resident A allegedly had while at this facility such as head banging were never brought up to her guardian or relatives. Relative #2 stated family members were in the facility every day and none of this was relayed to them.

On 11/18/2025, I reviewed the 1:1 staffing schedule set up for Resident B. This document showed 1:1 supervision for each shift beginning on 08/22/2025 through 09/27/2025.

On 11/24/2025, I conducted an exit conference with Sharon Cuddington, Licensee Designee via telephone. Ms. Cuddington stated she agreed with the information, analysis, and conclusion of this applicable rule.

APPLICABLE RULE	
R 400.681	**Resident rights; licensee responsibilities.**
	(1) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe.
ANALYSIS:	The complainant reported Resident A was assaulted by Resident B in this facility and no one at the facility did anything about it. Resident's A & B were issued 30-day discharge notices after the incident occurred and a 1:1 supervision schedule was set-up for Resident B after the physical altercation took place. Based on a review of facility documents and interviews with staff and medical personnel, there is not a preponderance of evidence to show that staff failed to provide protection and safety to the residents. A violation of this applicable rule is not established.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ADDITIONAL FINDING

INVESTIGATION: On 10/09/2025, I reviewed Resident A's weight record dated 03/18/2025 through 09/09/2025. The weight record did not have a weight documented for 06/2025.

On 11/18/2025, I reviewed an excel spreadsheet with Resident A's weights documented and the weight record did not have a weight documented for 06/2025.

On 11/24/2025, I conducted an exit conference with Sharon Cuddington, Licensee Designee via telephone. Ms. Cuddington stated she understood the additional finding and will meet with Ms. Treakle and nursing to make sure monthly weights are completed, documented, and if there is a change in the resident's weight, the residents primary care provider is notified.

APPLICABLE RULE	
R 400.691	**Resident records.**
	(g) Admission and monthly weight record.

ANALYSIS:	There is no weight documented for Resident A for the month of June 2025. Therefore, a violation of this applicable rule is established.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

11/24/2025

Elizabeth Elliott — Date
Licensing Consultant

Approved By:

11/24/2025

Jerry Hendrick — Date
Area Manager