



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

MARLON I. BROWN, DPA  
DIRECTOR

November 20, 2025

Jennifer Herald  
Oliver Woods Retirement Village LLC  
Suite 200  
3196 Kraft Ave SE  
Grand Rapids, MI 49512

RE: License #: AL780262260  
Investigation #: 2026A1033004  
Oliver Woods #2

Dear Ms. Herald:

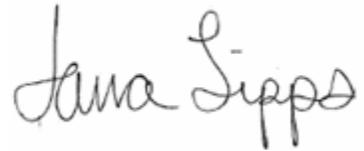
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (517) 335-5985.

Sincerely,

A handwritten signature in cursive script that reads "Jana Lipps". The signature is written in a dark ink and is positioned below the word "Sincerely,".

Jana Lipps, Licensing Consultant  
Bureau of Community and Health Systems  
611 W. Ottawa Street  
P.O. Box 30664  
Lansing, MI 48909

enclosure

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

**THE RESIDENTS CODED IN THIS INVESTIGATION ARE NOT CODED IN  
SEQUENTIAL ORDER AS THIS INVESTIGATION REFERENCES SPECIAL  
INVESTIGATION #2025A1033032.**

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	AL780262260
<b>Investigation #:</b>	2026A1033004
<b>Complaint Receipt Date:</b>	10/27/2025
<b>Investigation Initiation Date:</b>	10/27/2025
<b>Report Due Date:</b>	12/26/2025
<b>Licensee Name:</b>	Oliver Woods Retirement Village LLC
<b>Licensee Address:</b>	Suite 200 3196 Kraft Ave SE Grand Rapids, MI 49512
<b>Licensee Telephone #:</b>	(810) 334-8809
<b>Administrator:</b>	Carla LaMarr
<b>Licensee Designee:</b>	Jennifer Herald, Designee
<b>Name of Facility:</b>	Oliver Woods #2
<b>Facility Address:</b>	1320 W. Oliver St. Owosso, MI 48867
<b>Facility Telephone #:</b>	(989) 729-6060
<b>Original Issuance Date:</b>	04/16/2004
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	08/29/2025
<b>Expiration Date:</b>	08/28/2027
<b>Capacity:</b>	20

<b>Program Type:</b>	PHYSICALLY HANDICAPPED ALZHEIMERS AGED
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## II. ALLEGATION(S)

	<b>Violation Established?</b>
Resident C eloped from the facility due to lack of supervision from direct care staff.	Yes

## III. METHODOLOGY

10/27/2025	Special Investigation Intake 2026A1033004
10/27/2025	Special Investigation Initiated – Telephone call made. Interview conducted with Complainant, via telephone.
10/31/2025	Inspection Completed On-site- Interview conducted with Administrator, Carla LaMarr, walk through of facility completed. All exit routes observed.
10/31/2025	Contact - Document Received- Email correspondence received from Administrator, Carla LaMarr.
11/04/2025	Contact - Telephone call made- Attempt to interview direct care staff, Danielle Smith, via telephone. Voicemail message left, awaiting response.
11/04/2025	Contact - Telephone call made- Attempt to interview direct care staff, Jessica Walker, via telephone. Voicemail message left, awaiting response.
11/04/2025	Contact - Telephone call made- Attempt to interview direct care staff, Nicole Chapman, via telephone. Ms. Chapman requested a call back on 11/6/25 after 4:30pm.
11/06/2025	Contact – Document sent- Email correspondence sent to Administrator, Carla LaMarr.
11/06/2025	Contact – Telephone call made- Interview conducted via telephone with direct care staff, Nicole Chapman.
11/10/2025	Contact – Telephone call made- Interview conducted via telephone with direct care staff, Jessica Walker.

11/10/2025	Attempt to interview direct care staff, Danielle Smith. Voicemail message left, awaiting response.
11/13/2025	Contact – Document received- Documents received via email from Administrator, Carla LaMarr.
11/20/2025	Exit Conference Conducted via telephone with licensee designee, Jennifer Herald, and Administrator, Carla LaMarr.

**ALLEGATION: Resident C eloped from the facility due to lack of supervision from direct care staff.**

**INVESTIGATION:**

On 10/27/25 I received an online complaint regarding the Oliver Woods #2, adult foster care facility (the facility). The complaint alleged that on 10/22/25 Resident C eloped from the facility and was found about five to seven minutes later, near the entrance of the property. The complaint stated that Resident C was returned to the facility and was not injured. On 10/27/25 I interviewed Complainant, via telephone. Complainant reported that the incident occurred on 10/22/25 around 6:40pm. She reported that there were three direct care staff members (names not known) working at the time of Resident C’s elopement. Complainant reported that Resident C had been sitting in the common area in a chair while two of the direct care staff were working on a Hoyer lift transfer with another resident and the third direct care staff member had been called into another resident bedroom to assist with personal care. Complainant reported that the direct care staff members heard a door alarm sound but could not leave the residents they were caring for to immediately check the alarm. Complainant reported that once the Hoyer transfer had been completed the direct care staff went to the common area to look and found that Resident C was no longer sitting in her chair. She reported that an elopement procedure was activated and it was communicated to each licensed adult foster care facility on the campus (four facilities in total), that Resident C had left the facility. Complainant reported that direct care staff searched the parking lot and were able to locate Resident C at the end of the driveway, leading to the street. Complainant reported that Resident C was found about 20 feet off the facility property and that Resident C was near a neighboring house and the occupant of this home directed the direct care staff to Resident C. Complainant reported that Resident C was admitted to the facility in August 2025, with elopement behaviors. Complainant reported that Resident C experiences a phenomenon known as “Sundowners” which causes her to have her days and nights confused. Complainant reported that after the evening meal, Resident C seems more restless and the direct care staff have noticed exit seeking behaviors at this time of day. Complainant reported that Resident C has previously exited through a side door of the facility but this door is also alarmed and leads to a gated patio, where Resident C does not have access to the street. Complainant reported that the direct care staff are looking to increase supervision and

activities with Resident C after the evening meal and the management is in the process of hiring and scheduling additional direct care staff for supervision purposes.

On 10/31/25 I conducted an unannounced, on-site investigation at the facility. I conducted a walkthrough of the facility with Administrator, Carla LaMarr. Ms. LaMarr explained that the facility has eight available exits. Four of these exits (#20, 21, 22, 23) are alarmed with a standard door alarm and lead to a gated patio area. The two main means of egress (#1 & #2) are alarmed with a 15 second delayed egress alarm and lead to corridors with immediate access to additional doors (#5 & #7) that lead to the parking area. The facility has two additional doors (#6 & #28) alarmed with a 15 second delayed egress alarm, which lead directly to the parking lot. Ms. LaMarr explained on 10/22/25, Resident C was able to elope from exit #1 by holding down the door handle and waiting 15 seconds for the delayed egress to activate and open the door. She reported that Resident C then walked out exit #5 (which does not have any alarm installed) and gained immediate access to the parking lot. She reported that Resident C walked with her walker to the end of the driveway and turned left on Oliver St. She reported that Resident C was found by direct care staff on the sidewalk off Oliver St. in front of a neighboring home, just off the property line. Ms. LaMarr reported that management and direct care staff have implemented louder door alarms for all exits, which were tested while I was on-site. She reported that each shift has been staffed with three direct care staff members, prior to Resident C's elopement on 10/22/25. Ms. LaMarr reported that the facility currently has two residents who actively exit seek, Resident C and Resident D. She reported that she is trying to increase activities with these residents to provide additional cognitive stimulation and supervision. She also reported that she is working on adding a fourth direct care staff member from 6pm to 10pm as this is the busiest time of the day for direct care staff as the residents are finishing dinner, requiring personal care assistance, and getting ready for bed. Ms. LaMarr reported on the evening of 10/22/25 she was informed by direct care staff, Danielle Smith, of Resident C's elopement. Ms. LaMarr reported that she immediately reported the elopement to licensee designee, Jennifer Herald. Ms. LaMarr reported that she and Ms. Herald have held meetings on how to increase resident safety and supervision in the wake of this event, including increasing direct care staff scheduled to work and adding activities for residents. She was open to input from this consultant on other ideas to assist with Resident C and Resident D's elopement behaviors.

During the on-site investigation on 10/31/25 I reviewed the following documentation:

- *Assessment Plan for AFC Residents* document for Resident C, dated 7/24/25. On page one, under section, *I. Social/Behavioral Assessment*, subsection, *A. Moves Independently in Community*, the document is marked, "Yes", with no written narrative. Under subsection, *D. Alert to Surroundings*, the document is marked, "No", with the written narrative, "Exit seeks [Resident C] believes she is a young child looking for her mother."
- *AFC Licensing Division – Incident/Accident Report*, for Resident C, dated 10/22/25. Under the section, *Explain What Happened/Describe Injury*, it reads, "[Resident C] who resides in Memory Care & is exit seeking eloped out of [the facility] while staff were attending to other residents. Resident was located after

elopement was called and found on sidewalk by end of drive off property. She was redirected back into facility with an estimated time off property 5-7mins.” Under the section, *Action Taken by Staff/Treatment Given*, it reads, “Staff assisted resident back to [the facility], and notified [Ms. LaMarr], POA, and PCP of incident. [Ms. LaMarr] notified [Ms. Herald] and the following day met with Regional Wellness & Ops for interventions. Spoke with both family and State Lic.”

- *Internal Incident Report Form*, for Resident C, dated 10/22/25, completed by direct care staff, Danielle Smith. Under the section, *Nursing Description*, it reads, “Was in with another resident when coming out heard alarm, looked for [Resident C], called code silver when unable to locate in building.” Under the section, *Action Taken*, it reads, “Found resident, got her back in the building. Made proper phone calls.” On Page two, under the section, *Notifications*, the document indicates that the direct care staff notified Relative A1, Home MD, Ms. LaMarr, Ms. Herald, and adult foster care licensing consultant, Bridget Vermeesch, regarding the elopement.

On 10/31/25 I received the following documents via email correspondence with direct care staff, Helen Sheets, at the facility.

- *Health Care Appraisal*, for Resident C, dated 6/26/25. Under section, 7. *Diagnoses*, it reads, “Diabetes, hypertension, hypothyroid, hyperlipidemia, multiple sclerosis, dementia.”
- *Service Plan Report*, for Resident C, dated 8/1/25. On page one, under section, *Community Movement*, subsection, *Goal*, it reads, “Will be supervised with movement around the community and off campus grounds.” Under subsection, *Interventions*, it reads, “[Resident C] requires supervision both on and off campus grounds and while on off campus trips.” Under the section, *Assurance Checks*, subsection, *Goal*, it reads, “Will maintain safety while living in community.” Under subsection, *Interventions*, it reads, “Assurance checks provided for safety and supervision”. On page four, under section, *Reasoning*, subsection, *Goal*, it reads, “Will make appropriate decisions about their care and environment with assistance.” Under subsection, *Interventions*, it reads, “[Resident C] requires assistance with redirection due to confusion, deficits in judgement, wandering or exit seeking. [Resident C] has the mindset she is a teenager and is actively seeking her mother. Care staff will report any changes in ability to reason.”
- *Medication Administration Record* for Resident C for the month of October 2025. On page five there is an assigned task recorded as, *Supervision Monitoring – Baseline*. There are six times per day direct care staff are scheduled to check on Resident C, 2am, 6am, 12pm, 2pm, 5pm, 10pm. On 10/22/25 each of these times was documented by direct care staff as being performed.
- *Direct care staff schedule* for 10/22/25. This document identified that the three direct care staff scheduled at the facility at the time of Resident C’s elopement were, Danielle Smith, Nicole Chapman, and Jessica Walker.

On 11/6/25 I interviewed direct care staff, Nicole Chapman, via telephone, regarding the allegations. Ms. Chapman reported that she had been working at the facility on the date of Resident C's elopement. She reported that there were three direct care staff scheduled at the facility on this date, herself, Danielle Smith, and Jessica Walker. Ms. Chapman reported that Ms. Walker was a new direct care staff and was still in training. She reported that she and Ms. Walker had been in Resident E's bedroom conducting a Hoyer lift transfer and providing personal care to Resident E. She reported that she was not certain whether they heard the door alarm sound when Resident C eloped from the building. Ms. Chapman reported that she could not recall whether the door alarm was heard. She reported that when they finished conducting Resident E's care and went back into the common area, where Resident C had last been seen, Resident C was gone. She reported that Resident C had previously been pacing back and forth in the common area. She reported that this is normal behavior for Resident C as she is always pacing and looking for exits. She reported that Ms. Smith had been tending to another resident in another bedroom and came out when she heard that Resident C was missing. Ms. Chapman reported that Ms. Smith and Ms. Walker went to look for Resident C and they informed the other three licensed adult foster care facilities on this campus that Resident C had eloped from the building. Ms. Chapman reported that she stayed in the facility as someone had to be present with the other residents. Ms. Chapman reported that Resident C was located, off the property, at the neighboring house. She reported that an occupant of the neighboring home had seen Resident C and was "keeping her warm" until they could inform the facility of her whereabouts. Ms. Chapman was not certain whether Resident C went inside the neighboring home for warmth or was just on the porch. She reported that Ms. Smith and Ms. Walker were able to escort Resident C back to the facility. Ms. Chapman reported that she does not feel the staffing at the facility is adequate. She reported that there are multiple residents who require two direct care staff assistance with mobility, transfers, and personal care. She identified these residents as Resident E, Resident F, Resident B, and Resident A. Ms. Chapman reported that Resident E requires two direct care staff assistance as she is obese and lifting her with one person is not possible or advisable. She reported Resident F requires two direct care staff and at times three direct care staff assistance. She clarified that Resident F will get himself onto the floor by sliding out of his chair and will not be able to get himself back up. She reported that when Resident F does this, it can take up to three direct care staff to lift him back to his seat. She reported that Resident F ends up on the floor at least once per day. She reported that the direct care staff have spoken with his hospice provider about the issue and the recommendation they received from the hospice provider was to give him a pillow and blanket and leave him on the floor. Ms. Chapman reported that she is aware this is not allowed and would never leave Resident F on the floor of the facility. Ms. Chapman reported that Resident B requires one to two direct care staff to perform personal care, transfers, and mobility tasks, "depending on who is working". She clarified that Resident B can be challenging for one staff to assist due to his size and unskilled or not as strong direct care staff may need additional assistance to transfer him. Ms. Chapman reported that Resident A requires two to three direct care staff to assist with his care due to his size. She reported that Resident A requires a Hoyer lift for transfers and it can take two direct care staff to work the Hoyer lift and a third direct care staff to hold his legs. Ms. Chapman

reported that Resident C should have a one-to-one sitter with her at all times due to her exit seeking behaviors. She reported that it is too challenging for the direct care staff to provide for the other residents' personal care and keep a constant eye on Resident C. She also noted concern about new hires being viewed as competent direct care staff on the staff schedule. Ms. Chapman reported that when she has to train a new direct care staff member, as was the case the evening of 10/22/25, when Resident C eloped from the facility, it is challenging to be able to manage all the tasks required during a shift as you are spending a large portion of your shift training another individual. Ms. Chapman reported that on 10/22/25, Ms. Smith was scheduled to perform the task of medication administration. She reported that the direct care staff who are scheduled as medication administration on the schedule, do not usually assist with resident personal care. She reported that there are times when direct care staff scheduled to administer medications are scheduled at multiple facilities on this campus at the same time. Ms. Chapman reported that she has voiced her concerns about the current staffing levels to Ms. Sheets. She reported that there was a night when she is aware Ms. LaMarr came in to cover a shift at 11pm due to low staffing, but overall, she feels the staffing is not adequate for the needs of the current residents.

On 11/10/25 I interviewed Ms. Walker, via telephone, regarding the allegation. Ms. Walker reported that she was working on the date of Resident C's elopement from the facility. She reported that this was her first date scheduled since being rehired at the facility. She reported that 18 years prior she had worked at the facility and was returning in the capacity of Wellness Team Supervisor. Ms. Walker reported that her job description involves overseeing direct care staff, scheduling direct care staff, and sometimes working as a direct care staff when needed. Ms. Walker reported that 10/22/25 was her first shift and she was in training on this date. She reported that Ms. Chapman was training her and she was assisting Ms. Chapman with Resident E's personal care when Resident C eloped. Ms. Walker reported that the last place she visually observed Resident C was in the common area, "doing laps", when she and Ms. Chapman entered Resident E's bedroom to perform personal care. Ms. Walker reported that she did not hear the door alarm sound while they were in Resident E's bedroom. She reported that when they exited Resident E's bedroom and made their way back to the common area, Resident C was gone. Ms. Walker reported that Ms. Chapman left the facility and went looking for Resident C. She reported that Ms. Smith had been assisting another resident and started looking for Resident C. Ms. Walker reported that she remained in the facility to watch over the other residents while Ms. Chapman and Ms. Smith left the facility searching for Resident C. Ms. Walker reported that Ms. Chapman was able to locate Resident C at the neighboring house and escort her back to the facility. Ms. Walker reported that there are currently four residents who require two direct care staff assistance with mobility, transfers, or personal care who reside at the facility. She reported that she judges who needs a two direct care staff assistance based upon whether they use a device for transfers such as a Hoyer lift or a Sit-to-Stand machine. She reported that the four residents who require a two direct care staff assistance are Resident E, Resident F, Resident A, and Resident G. She further reported that Resident E, F, & A require the use of a Hoyer lift and Resident G requires a Sit-to-Stand device. Ms. Walker reported that Resident F and Resident A are not

weight bearing. She reported that Resident G is not always strong enough to hold her own weight due to Parkinsons Disease and should not be transferred with one direct care staff. Ms. Walker reported that since Resident C's elopement the facility has instituted a plan where there cannot be all three direct care staff scheduled in a resident room at the same time. She reported that at least one direct care staff on each shift is required to be in the common area monitoring for elopement risks.

On 11/10/25 I received email correspondence from Ms. LaMarr in response to an email message I had sent her requesting additional information. Ms. LaMarr reported that the facility currently has four residents who require a two direct care staff assistance with mobility, transfers, and/or personal care. Ms. LaMarr also reported that she has hired additional direct care staff, who are currently being scheduled for orientation and by 11/14/25 she should be able to add a fourth direct care staff to the direct care staff schedule at the facility. I also reviewed the following documents which Ms. LaMarr provided in this email correspondence:

- *Service Plan Report*, for Resident D, dated 7/9/25. On page one, under section, *Assurance Checks*, subsection, *Interventions*, it reads, "Assurance checks provided hourly checks for safety and supervision." Under section, *Reasoning*, subsection, *Interventions*, it reads, "[Resident D] is oriented to person. [Resident D] does not have a reality concept of certain situations. All and has frequent delusions. [Resident D] does require assistance with redirection due to occasional confusion, deficits in judgement, wandering or exit seeking. [Resident D] has a history of hallucinations and will revert back to his time working as a detective."
- *Assessment Plan for AFC Residents*, for Resident D, dated 2/1/25. On page one, under section, *I. Social/Behavioral Assessment*, subsection, *A. Moves Independently in Community*, the document is marked, "yes". Under subsection, *D. Alert to Surroundings*, the document is marked, "No", with the following narrative, "Has a history of delusions and hallucinations."

On 11/13/25 I received email correspondence from Ms. LaMarr, providing documentation for the four residents she noted on 11/10/25, who require a two direct care staff assistance with mobility, transfers, and/or personal care. I reviewed the following documents:

- *Service Plan Report*, for Resident F, dated 3/27/25. On page one, under section, *Transfers*, subsection, *Interventions*, the document notes that Resident F requires the use of a Hoyer lift with transfers. Under section, *Falls*, subsection, *Goal*, the document states, "[Resident F] often crawls out of bed and lays on the floor. Hospice ordered resident a 9in foam mattress for resident to use while laying on the floor when resident does not want to be in his bed." On page three, under section, *Evacuation/Emergency Assistance*, subsection, *Intervention*, the document notes that Resident F only requires the assistance of one direct care staff member with evacuation from the facility.
- *Service Plan Report*, for Resident B, dated 4/29/25. On page one under section, *Transfers*, subsection, *Interventions*, the document notes that Resident B requires a Hoyer lift for transfers. On page two, under section,

*Evacuation/Emergency Assistance*, subsection, *Interventions*, the document notes that Resident B only requires one direct care staff member to assist with evacuation from the facility.

- *Service Plan Report*, for Resident A, dated 6/11/25. On page one, under section, Transfers, subsection, Interventions, the document notes that Resident A requires the use of a “Hoyer lift with a green sling” for transfers. On page two, under section, Evacuation/Emergency Assistance, subsection, Intervention, the document notes, “Resident requires assistance of 2 or more staff with evacuation.”
- *Service Plan Report*, for Resident G, dated 4/29/25. On page one, under section, Transfers, subsection, Interventions, the document notes that Resident G requires assistance with getting in and out of bed, chair, car, and that Resident G requires the use of a mechanical lift “sit to stand/Hoyer”. On page two, under section, Evacuation/Emergency Assistance, subsection, Intervention, the document notes that Resident G only requires assistance of one direct care staff member with evacuation.
- *Oliver Woods Assisted Living*, direct care staff schedule for Building #2, for the dates 10/1/25 – 10/22/25. I made the following observations on this schedule:
  - On 10/1/25 there was one direct care staff scheduled between 2pm -3pm.
  - On 10/4/25 there was one direct care staff scheduled between 10pm-11pm.
  - On 10/7/25 there were two direct care staff scheduled from 6pm to 6:30am. Next to Danielle Smith’s name the schedule reads “Meds (b1 and b2 at 10pm)”.
  - On 10/13/25 there was one direct care staff scheduled from 630am-8:45am and between 2:30pm-6pm.

On 6/5/25, Special Investigation #2025A1033032 cited a rule violation of Rule 400.15206, Staffing requirements. (2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan. The analysis of special investigation #2025A1033032 noted there were two residents at the facility who required a two direct care staff assistance with mobility, transfers, and/or personal care and that there were dates when only one direct care staff member was scheduled to provide care at the facility. The *Corrective Action Plan* (CAP), dated 4/29/25, and completed by Licensee Designee, Jennifer Herald, noted, that effective 4/29/25 there will always be two direct care staff members scheduled on all shifts when the facility is caring for any resident who requires a two direct care staff assistance with mobility, transfers, and/or personal care. Adult foster home rules were updated and promulgated on 11/3/2025 and Rule R. 400.15206 (2) is equivalent to Rule R. 400.671 (4).

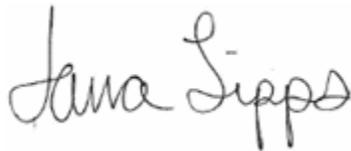
<b>APPLICABLE RULE</b>	
<b>R 400.671</b>	<b>Resident care.</b>
	<b>(4) A licensee shall provide supervision, protection, and personal care as specified in a resident's assessment plan. A hospice service plan, do-not resuscitate order, or any other advance directive must be included as an addendum to the resident assessment and maintained with the assessment plan in the resident's record.</b>

<b>ANALYSIS:</b>	<p>Based upon interviews conducted, documents reviewed, and a walkthrough conducted at the facility, it can be determined that the facility has not been adequately staffed to manage the care of the current residents. During the investigation it was identified that Resident C &amp; Resident D have exit seeking behaviors and this is well known to the direct care staff and administration. It was noted that both Resident C and Resident D watch exit doors and look for opportunities to elope from the facility. It was also reported by Ms. LaMarr, Ms. Chapman, and Ms. Walker, that there are at least four residents who require a two direct care staff assistance with mobility, transfers, and/or personal care, in addition to Residents C and D who have exit seeking behaviors. Each agreed that Resident F &amp; A require a two direct care staff assistance, while it was also mentioned that Residents E, B, and G also require a two direct care staff assistance. Ms. Chapman reported that there are times the facility is staffed with one direct care staff for resident personal care and one direct care staff to manage medication administration and at times the direct care staff member responsible for medication administration is also assigned to more than one licensed adult foster care facility on the campus concurrently. There are at least four residents, possibly more, given the discrepancy in responses between Ms. LaMarr, Ms. Chapman, and Ms. Walker, who require a two direct care staff assistance with mobility, transfers, and/or personal care. Furthermore, Ms. Chapman and Ms. Walker presented contradictory details about what occurred on the night of Resident C's elopement in terms of which direct care staff member left the facility to find Resident C. Both Ms. Walker and Ms. Chapman stated that they stayed behind to watch the other residents and noted that the other two direct care staff on duty went looking for Resident C. Both Ms. Chapman and Ms. Walker reported that Resident C had been actively exit seeking prior to their entry into Resident E's bedroom and all three direct care staff were required to tend to other resident personal care needs and left Resident C unsupervised. This facility has eight available exits, four of which can lead to the parking area. Resident C's <i>Service Plan Report</i> did not list any interventions for direct care staff to follow or attempt with Resident C to increase her safety during episodes of active exit seeking. Additionally, the direct care staff schedule identified time intervals on 10/1/25, 10/4/25, and 10/13/25 where only one direct care staff member was scheduled to work at the facility. It also identified on 10/7/25 after 10pm there were two direct care staff scheduled to work at the facility but one was also assigned to administer medications at another licensed facility on the campus. If this direct care</p>
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	staff member had to leave the facility to administer medication at another licensed facility on the same campus that would decrease the staffing at the facility to one direct care staff. Leaving the facility with one direct care staff member puts all residents in an unsafe situation. Based on these findings, a violation has been established.
<b>CONCLUSION:</b>	<b>REPEAT VIOLATION ESTABLISHED [SEE SIR#2025A1033032 Rule 206.2, AND CAP DATED 4/29/25.]</b>

**IV. RECOMMENDATION**

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



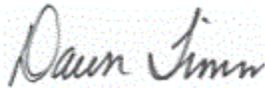
11/19/25

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Jana Lipps  
Licensing Consultant

Date

Approved By:



11/20/2025

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Dawn N. Timm  
Area Manager

Date