GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

November 20, 2025

Jennifer Bhaskaran
Alternative Services Inc.
Suite 10
32625 W Seven Mile Rd
Livonia, MI 48152

RE: License #: AS330311852
Investigation #: 2026A0622001
Willoughby Home

Dear Ms. Bhaskaran:

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,

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

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS330311852
Investigation #:	2026A0622001
Complaint Receipt Date:	10/03/2025
Investigation Initiation Date:	10/06/2025
Report Due Date:	12/02/2025
Licensee Name:	Alternative Services Inc.
LicenseeAddress:	Suite 10 32625 W Seven Mile Rd Livonia, MI 48152
Licensee Telephone #:	(248) 471-4880
Administrator:	Jennifer Bhaskaran, Designee
Licensee Designee:	Jennifer Bhaskaran, Designee
Name of Facility:	Willoughby Home
Facility Address:	5343 Willoughby Road Lansing, MI 48911
Facility Telephone #:	(517) 394-9699
Original Issuance Date:	07/01/2011
License Status:	REGULAR
Effective Date:	01/21/2024
Expiration Date:	01/20/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident A is reportedly being left soiled at night at Willoughby Home, leading to ongoing vaginal infections, likely caused by poor hygiene.	Yes
Additional Findings	Yes

III. METHODOLOGY

10/03/2025	Special Investigation Intake 2026A0622001
10/06/2025	Referral came from APS
10/06/2025	Special Investigation Initiated – Email contact with adult protective services worker, Robert Joyner
10/07/2025	Phone calls to Guardians A1 and B1
10/22/2025	Inspection Completed On-site
10/24/2025	Phone call to community mental health case worker, Kayla Spitzley.
11/03/2025	Phone call received from Guardian A1
11/06/2025	Phone calls to direct care workers, Cynthia Milton, Paradise Godard and Erica Montgomery
11/06/2025	Voicemails were left for Resident A and B's doctors.
11/14/2025	Additional documentation requested from Willoughby Home manager, Tasia Churchill.
11/17/2025	Contact, voicemails left for direct care workers, Erica Montgomery and Emily Santos. Phone interview with direct care worker Alison Heppard.
11/18/2025	Phone call to Guardian A1
11/20/2025	Exit Conference with licensee designee, Jennifer Bhaskaran and phone call to Operations Director, Tamie Stevens.

ALLEGATION: Resident A is reportedly being left soiled at night at Willoughby Home, leading to ongoing vaginal infections, likely caused by poor hygiene.

INVESTIGATION:
On 10/03/2025, I received this complaint through the LARA Bureau of Community and Health Systems online complaint system. According to the complaint, there is concern that Resident A is not being changed at night, as she is being found soiled in the morning. Resident A is having ongoing issues with vaginal infections, likely due to poor hygiene. The complaint reported that Resident B is not changed at night, as he is found to be soiled in the morning. The complaint stated that due to the lack of changing, Resident B is having a skin breakdown around his bottom.

On 10/06/2025, I interviewed adult protective services worker, Robert Joyner via email. Mr. Joyner provided contact information for Guardian A1 and Guardian B1. Mr. Joyner reported that a staff meeting was held and he was informed the situation was improving.

On 10/07/2025, I left a voicemail for Guardian B1.

On 10/07/2025, I interviewed Guardian A1 via phone. Guardian A1 reported that she is being told by daytime direct care workers, that Resident A is found wet and soaking her bed in the mornings when daytime staff arrive. Guardian A1 reported that the home has been going through different home managers in the last few months. Guardian A1 stated that Resident A has been having urinary tract infections often. Guardian A1 stated Resident A does not wear incontinence briefs and can verbally inform direct care workers if she needs to use the bathroom.

On 10/22/2025, I completed an unannounced onsite investigation to Willoughby Home. During the unannounced onsite investigation, I interviewed direct care workers and viewed documents for Resident A and Resident B.

I interviewed direct care worker (DCW), Michelle Stewert in person. She reported that she has worked at Willoughby Home for one year and mainly works first shift five days a week. DCW Stewart explained that at least three days a week, she comes into her shift and finds Resident A soaked from the neck down and also finds Resident B's brief soaked. DCW Stewart stated that Resident B is usually still sleeping when she arrives at 6am and sometimes Resident A will be awake. DCW Stewart reported that currently Resident B has a sore on his bottom and Resident A has an odor. She explained that she will often need to wash Resident A's sheets multiple times a week, as she wets through them. DCW Stewart explained that recently at a staff meeting, staff were told to not wake up residents to change them if they are sleeping, by operations director, Tamie Stevens.

I interviewed direct care worker, Chelcee Custer in person. She stated that she has worked at Willoughby Home for 30 days and only works first shift. DCW Custer stated that when she arrives, she will find Resident A wet, head to toe, at least twice

a week. She explained that she finds Resident B soaked through his brief in the morning. DCW Custer stated that Resident A is having frequent infections. DCW Custer stated she noticed staff are not properly washing her private area, by leaving soap on her vagina, which continues to lead to an odor and infections. DCW Custer stated that Resident A requires a shower every morning. DCW Custer explained that Resident B wears an incontinence brief all day and has a sore on his crack of his bottom. She reported “if [Resident A] is that soaked, they are not checking her, as she is wet from the top of her head to the bottom of her feet.” DCW Custer stated that they recently had a staff meeting to discuss changing residents more often, but none of the third shift staff members were present for the meeting. DCW Custer stated that at the staff meeting, staff were told by operations director, Tamie Stevens to not wake up residents to change them even if they are sleeping and wet.

I interviewed direct care worker, Sherika McGruder in person. She stated that she has only worked at Willoughby Home for three weeks and only works from 8am-5pm. DCW McGruder stated that Resident A and Resident B are already awake when she arrives. She explained that she has noticed that Resident A will have some toileting accidents.

I interviewed direct care worker, Tasia Churchill in person. DCW Churchill described her role as the home manager. DCW Churchill confirmed that Resident B has an abscess on his bottom, but it is improving, and Resident A has been having recurrent vaginal infections. She explained that a meeting was held in September 2025 with all staff and she has noticed some improvements with keeping the residents dry. Another meeting was held on 10/17/25, but none of the third shift workers were present for the meeting. DCW Churchill stated that third shift should be showering residents if they are awake before 6am. DCW Churchill explained that she is concerned that direct care worker, Erica Montgomery is not completing her required duties in providing personal care for residents.

Resident A and Resident B’s *Assessment Plan for AFC Residents* were reviewed and documented the following under each section:

Toileting

- Resident A: “Needs staff assistance with transferring on and off toilet. Help with wiping with bowel movements.”
- Resident B: “Uses toilet independently, but will need help with wiping. Wears briefs for occasional accidents.”

Bathing

- Resident A: “Requires full assistance from staff for all bathing needs, uses a shower bench.”
- Resident B: “Requires ongoing total staff support.”

Grooming:

- Resident A: “Requires staff assistance.”
- Resident B: “Requires ongoing total staff support.”

Personal Hygiene:

- Resident A: “Requires staff assistance for thoroughness.”
- Resident B: “Requires ongoing total staff support.”

I viewed daily shower charts for Resident A and Resident B. Resident A received a shower daily from October 1st-21st. Comments on her chart included morning showers, which she received 13 morning showers during that timeframe. Resident B’s shower charts were viewed for the month of October 1st-21st. Resident B received 16 daily showers. According to the chart the longest he went without receiving a shower was two days. His chart stated that he received 7 morning showers.

I viewed documentation for body checks for Resident A and Resident B. Body checks are completed weekly for each resident. According to Resident A’s body checks from July 2025- October 2025, no concerns were documented. Resident B’s body check form was viewed and according to the forms, Resident B had a documented bottom sore on 8/30/25 and 10/4/25.

I viewed medical visit forms for Resident A. The first medical visit form viewed was from 4/8/25. Dr. Chartier prescribed Nystatin powder once daily after showers for a rash, along with a nightly wedge pillow and bamboo pads for barrier protection.

A medical visit form was viewed for Resident A from 7/22/25 from Dr. Chartier. According to the form, Resident A was seen for vaginal odor and discharge. Resident A had vaginal swaps collected and all were negative. The medical form stated: “Due to the severity, persistence and clinical exam, will treat for a yeast and bacterial infection.” Two new prescriptions for yeast and bacterial infections were sent to the pharmacy. Resident A was also prescribed a daily probiotic.

A medical visit form was viewed for Resident A from 8/22/2025 from Dr. Chartier. According to the form, Resident A was seen for a follow up regarding her visit from 8/22/25. The medical visit form stated that testing confirmed bacterial infection and Resident A needed longer therapy as her infection re-occurred after treatment. Three new prescriptions for infections were sent to the pharmacy.

A medical visit form was viewed for Resident A from a urgent care visit. The form stated that Resident A was coming to the doctor for red eye and discharge. No documentation was available for treatment for her discharge.

A medical visit form was viewed for Resident A from 9/30/25 from Dr. Chartier. The medical form stated Resident A was seen for a follow up from her urgent care visit due to conjunctivitis and vaginal odor and discharge. Dr. Chartier reported the following regarding care for Resident A’s bacterial vaginosis; “stop metronidazole gel, start Diflucan RX, total of 3 tabs. Be diligent about proper hygiene with daily showers and cleaning area.”

Medical visit forms were viewed for Resident B from 8/29/25 from a house doctor. Resident B was seen due to eye crusting, diarrhea, confusion, weight loss, pain, and knot/lump on bottom. According to the form, Resident B had an abscess on his bottom, and a prescription was sent to the pharmacy.

A medical visit form was viewed for Resident B from 10/27/25 from Dr. Roper. Resident B was seen at the doctors for diarrhea and weight loss. Dr. Roper prescribed Destin cream for the brief area for skin breakdown. It was prescribed daily and as needed.

On 11/6/25, I left a voicemail for direct care worker Erica Montgomery.

On 11/6/025, I interviewed direct care worker, Cynthia Milton via phone. DCW Milton stated that she has worked at Willoughby Home for 8 years and works third shift. She described her duties during third shift as preparing meals for the next day, laundry, cleaning bathrooms, mopping the floors, bed checks every two hours and caring for the residents as needed. DCW Milton stated that she always works with another staff member. She explained that all residents wear briefs, except Resident A. DCW Milton stated that Resident A will call for a staff member if she needs to use the bathroom. She stated that usually Resident A will sleep through the night until sometime between 4am-6am to use the bathroom and then will go back to bed. DCW Milton reported that usually the last bed check is at 5am, as staff have paperwork to complete. She explained that sometimes direct care workers go back at 5:30am and re-check the residents. DCW Milton reported that third shift does not shower the residents, unless the resident is awake and soiled. DCW Milton reported that she tries her best to make sure Resident A is dry before she leaves her shift. DCW Milton reported direct care workers were informed to not wake up residents to use the bathroom and if they are wet, they will wake up on their own. She reported that this direction came from operations director, Tamie Stevens. DCW Milton stated that Resident B takes a long time to wake up and usually needs to sit on the side of the bed for some time, before moving to the bathroom. DCW Milton reported that she has not seen a sore on Resident B’s bottom and is not aware of any sore he may currently have.

On 11/6/25, I interviewed direct care worker, Paradise Godard via phone. She reported that she works third shift and has not worked with Erica Montgomery and mainly works with Cythnia Milton. DCW Godard stated that she works three days a week and has offered to stay over onto first shift to assist with resident care. DCW Godard stated that third shift often gets the blame for not changing residents and first shift does not want to deal with Resident A. DCW Godard stated that residents are never left wet during her shift. She explained that Resident A will sleep all night and usually wakes up around 6:10am-7am. She stated that Resident A will tell staff when she needs to use the bathroom or if she is wet. DCW Godard stated that Resident B wears a brief all day but is put on the toilet many times a day. DCW Godard stated that she will often come in for her third shirt to find residents wet and

needing to be changed. DCW Godard stated that the staff are struggling to work as a team.

On 11/6/25, I left a voicemail for Resident A's doctor but was able to interview Resident B's doctor, and he was requesting confirmation of a release to provide additional details regarding Resident B. Forms were mailed to his office on 11/13/25.

On 11/6/25, I interviewed Community Mental Health Caseworker, Kayla Spitzley via phone. She reported that Resident A had a rash in the month of April. She received no notes of concerns for the month of May and June, but Resident A has been having ongoing vaginal infections since July, 2025. Ms. Spitzley reported that the home had a lack of home managers for some time, therefore see feels there was a lack of oversight occurring. Ms. Spitzley explained that it's her understanding, that Resident B had a sore on his bottom starting in September and his abscess drained in October. She stated that she is informed by other direct care workers, that third shift is not completing personal care when the residents are wet during their shift, which is leading to increased infections and sores.

On 11/17/2025, a voicemail was left for direct care worker, Erica Montgomery.

On 11/17/2025, I interviewed direct care worker Alison Heppard via phone. She reported that she has been employed at Willoughby Home since July, 2025. She stated that works many different shifts, but has mainly been working second shift. DCW Heppard reported that when she worked first shift, Resident A was often soaked and yelling for staff when she arrived. She explained that Resident A was wet from head to toe, therefore DCW Heppard stated she believed Resident A must have had urinary incontinence more than just once. DCW Heppard reported that she felt that third shift was not always completing their duties as they would be sitting down, when first shift arrived. DCW Heppard reported that recently, Resident A has been wetting herself during the day possibly for staff attention. DCW Heppard explained that she noticed this behavior when new staff are working, as Resident A will urinate herself if the new staff member is assisting other residents. DCW Heppard explained that this is a new behavior within the last month or so from Resident A. She explained direct care workers try to change Resident A as soon as possible and are also trying to keep her as dry as possible. She explained that she never found Resident B wet upon arrival to work for first shift. DCW Heppard stated that Resident B does not like to wake up and prefers to sleep in. She explained that DCWs are to check and change Resident B every two hours. DCW Heppard reported that it's her understanding that she thinks the sore on his bottom started in September and that it's improving as she did not see it on Friday, November 14th.

On 11/17/2025, I interviewed direct care worker, Malaysia Aldridge via phone. She reported that she has worked both first and second shift. She reported that when she arrives at 6am for first shift she hears Resident A yelling for assistance and she will find her soaked. DCW Aldridge stated that occasionally, Resident A will still be sleeping, but the majority of the time she is awake at 6am. DCW Aldridge stated that

when she arrived on 11/16/25, she found Resident A with a bowel movement in bed and informed her manager of her concerns. DCW Aldrige reported that she always finds Resident B soaked all the way to his neck in the morning whether he is sleeping or awake for the day. DCW Aldridge stated that the changing or assisting residents in the middle of the night has been a concern for almost a year and recently staff were told not to wake residents up in the middle of the night to use the bathroom. She explained that staff were directed to not wake up residents to change them by operations director, Tamie Stevens.

On 11/20/2025, I interviewed operations director, Tamie Stevens via phone. She confirmed she attended the staff meeting and instructed direct care workers to not wake up Resident A to see if she was wet, as she would yell out if she needed to use the bathroom. Ms. Stevens further explained that she told staff that if the resident is sleeping and is not wet, to let the resident sleep. She reported that she encouraged staff to view the brief for the blue line while the resident is sleeping, and then only wake the resident up if they are wet and need to be changed. Ms. Stevens reported that staff took her instructions wrong, as she would never instruct staff to not change a resident when wet.

On 11/20/2025, I completed an exit conference with licensee designee, Jennifer Bhaskaran via phone. Ms. Bhaskaran reported that the statements that direct care workers are reporting from the staff meeting are not correct regarding their direction to change residents when wet. Ms. Bhaskaran stated that operations director, Tamie Stevens instructed direct care workers to not wake residents up every two hours to check them for wetness and she explained to staff that there are ways to check a resident for nighttime wetting without waking them up. Ms. Bhaskaran reported that operations director, Tamie Stevens instructed direct care workers to only wake a resident up if they find the resident wet and then properly change and clean the resident.

Special investigation report #2025A0622024, cited rule R.400.14303 (2) on 3/24/25 after it was determined during interviews with direct care staff that the third shift staff members were not providing personal care to Resident A, (which is the same Resident A being addressed in this current report) during sleeping hours, which caused an Erythematous rash to develop on Resident A’s posterior thigh in her gluteal fold. A corrective action plan was accepted and received on 4/9/25 which stated that all staff were in serviced on 4/3/25 that two-hour nightly bed checks are required and staff were to assist Resident A with going to the bathroom, changing if soiled and repositioning her. The corrective action plan also stated that staff will assist Resident A with using the bathroom as she calls for help. Adult foster home rules were updated and promulgated on 11/3/2025 and Rule R. 400.14303 (2) is equivalent to Rule R. 400.671 (4).

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:	Based upon interviews conducted and documentation reviewed it can be determined that there is adequate evidence that direct care workers are not providing for Resident A and B's personal care needs. According to their *Assessment Plans for AFC Residents* both residents require staff assistance with toileting, bathing, grooming and personal hygiene. During the investigation, I interviewed four direct care workers who work first shift and all reported regularly finding Resident A covered in urine, along with her bedding, when arriving to work at 6am and three direct care workers reported that they will find Resident B's brief to be soaked through when arriving to work at 6am. Two of the three third shift, direct care workers were interviewed via phone. Both, direct care workers, Cynthia Milton and Paradise Godard reported that they are checking on residents every two hours and are changing them if they are awake per direction from operations director Tammy Stevens. Both stated that they are attempting to make sure Resident A is dry before leaving for their shift at 6am. I attempted to reach the third direct care worker, Erica Montgomery, but no return call was received. Medical visit forms documented that Resident A has been having bacterial and yeast infections since July 2025. On the medical visit form dated 9/30/25, Dr. Chartier documented that staff need to be diligent about proper hygiene with daily showers and cleaning Resident A's private area thoroughly. A shower chart was reviewed for Resident A from October 2025 and Resident A was given a daily shower as directed by her physician. Direct care worker, Chelcee Custer reported in her interview that she has found that other staff are not properly washing Resident A and are leaving soap in her vagina, which is leading to an odor and infection. Medical visit forms documented that Resident B has been treated for an abscess on his bottom since 8/29/25 and was recently prescribed Destin Cream on 10/27/25 due to a skin breakdown. A previous violation was found on 3/24/25, due to staff not providing personal care needs to Resident A on third shift, which caused an Erythematous rash to develop on Resident A's posterior thigh in her gluteal fold. Based upon the documentation reviewed Resident A has only been free of a rash and infection for the months of May and June, as she was seen for an infection in July 2025. Due to the re-occurrent medical treatments needed for Resident A and B during the months of July-November, a violation has been established, as both residents require the assistance of direct care workers for personal care.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED. [SEE SIR #2025A0622024 AND CAP DATED 4/9/25].**

ADDITIONAL FINDING:

INVESTIGATION:

On 11/03/2025, I received a phone call from Guardian A1. Guardian A1 reported that Resident A was supposed to be transported to her monthly sisters outing at Panera at 1pm on 11/1/25. Guardian A1 stated that when Resident A was late, she contacted the home manager and was informed that she would be late, as staff thought the event was at 2pm. Guardian A1 then stated that she received another text not too long afterwards and stated that Resident A would not be coming as staff was not bringing her. Guardian A1 explained that she received no further information. Guardian A1 reported that she has other problems with staff bringing Resident A to her required monthly events. Guardian A1 stated that on 10/4/25, Resident A was supposed to be at Panera Bread at 1pm and staff brought her an hour late at 2pm, when everyone was leaving, therefore the staff member just ran in and bought her food, while leaving Resident A in the van. Guardian A1 reported that Resident A was unable to visit with any of her sisters due to being an hour late. Guardian A1 stated that on 9/21/25, staff were supposed to bring Resident A to mass at 2pm. Guardian A1 explained that the staff member bringing her didn't into the church until 2:50pm, therefore she missed most of the mass. Guardian A1 explained that the home manager told her that the staff member sat in the van with Resident A for 45 minutes. Guardian A1 stated that she is unsure why the home is having a hard time getting staff to transport Resident A to her required and agreed upon community events.

On 11/06/2025, I interviewed Community Mental Health Caseworker for Resident A, Kayla Spitzley. She confirmed that her community outings to Church and monthly visit with her sisters at Panera bread are documented in her Treatment Plan. According to Resident A's Treatment Plan the following was documented:

> *"I want to keep doing that on the weekends". [Resident A] expressed the desire to attend Church with her sister once a month. [Resident A] also expressed the desire to meet her sisters for lunch or coffee once a month. [Resident A] requires staff assistance to schedule and coordinate outings, and she requires staff assistance with transportation. These outings will be documented in the logs."*

I viewed Resident A's *Resident Care Agreement*, dated 3/6/25 and it states that the basic fee includes the following transportation services: medical appointments and community inclusion.

I viewed Resident A's *Assessment Plan for AFC Residents* and it stated that for recreation, Resident A attends MSU Music Therapy, goes out to eat, gets coffee and goes shopping. The column "For participates in religious practice"; the plan stated "no, chooses not to attend." The statement of "chooses not to attend" does not match what is documented in her treatment plan with Community Mental Health that was signed on

3/11/25 and the agreement with Guardian A1 to bring Resident A to church once a month.

I viewed *Community Inclusion Logs* for Resident A. According to the *Community Inclusion Log,* in August 2025, Resident A attended her sister's gathering at Panera on August 2nd and the 30th. There was no documentation of Resident A attending church in August. I viewed the September 2025 Community Inclusion Log which documented that Resident A did not attend a sisters gathering, but Guardian A1 stated that she attended on September 6th. The log stated that she attended church on 9/21/25 and had fun, but it was reported by Guardian A1 that Resident A was only present for the last ten minutes of church. The October 2025 Community Inclusion Log stated that Resident A attended church on 10/19/25 and there was no documentation of Resident A attending her sister's gathering at Panera Bread. On 11/1/2025, Resident A missed her sister's gathering at Panera Bread but was present for Church on 11/16/2025. Based on the Community Inclusion Logs, Resident A has not missed a MSU in person music class and Guardian A1 also confirmed this.

Special investigation report #2025A0622024, cited rule R 400.14301 **(**6) (a) on 3/24/25 after it was determined that staff at Willougby AFC were not transporting Resident A to her community inclusion activity MSU music class weekly as required. A corrective action plan was received on 4/9/25 and agreed to the following; "Resident A will attend music class and other activities as indicated in their plan of service, all staff will be in-serviced on Resident A's POS related to activities on 4/3/25 and Resident A activities will be included on the activity calendar for the home, that the home manager approves each month." Adult foster home rules were updated and promulgated on 11/3/2025 and Rule R. 400.14301 (6) (a) is equivalent to Rule R. 400.685 (6) (i).

APPLICABLE RULE	
R 400.685	**Resident admission; resident assessment plan; resident care agreement; health care appraisal.**
	(6) A licensee shall complete a written resident care agreement at the time of a resident's admission that includes all of the following: **(f) Transportation services provided for a basic fee and** **(i) An agreement by the licensee to provide care, supervision, and protection to the resident and to ensure transportation services as indicated in the resident's assessment plan and resident care agreement.**

ANALYSIS:	Upon review of Resident A's *Community Inclusion Logs* and interview with Guardian A1 it was determined that Resident A is not being transported consistently to the agreed upon community inclusion events of meeting her sisters for lunch/coffee once a month and also attending church once a month with her sisters. Based upon review of the *Resident Care Agreement,* signed on 3/6/25 Willoughby AFC agreed to provide transportation to community inclusion activities. Within the last four months, Resident A has missed two lunch/coffee events(October and November) with her sisters and two church events(August and 45 minutes late for September). A violation has been established as licensee designee, Jennifer Bhaskaran agreed to a corrective action plan on 4/9/25 stating that Resident A will attend all of her the community inclusion events listed within her treatment plan and has also agreed within the *Resident Care Agreement* to provide transportation for Resident A to her community inclusion activities.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED. [SEE SIR #2025A0622024 AND CAP DATED 4/9/25]**

IV. RECOMMENDATION

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

11/19/2025

_____

Amanda Blasius Date
Licensing Consultant

Approved By:

11/20/2025

_____

Dawn N. Timm Date
Area Manager