GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

December 2, 2025

Tina Schrump
The Chosen Vision
13279 Audrey Lane
Grand Ledge, MI 48937

RE: License #: AS190414436
Investigation #: 2026A1033006
Chosen Vision

Dear Ms. Schrump:

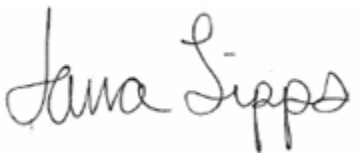
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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,



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

I. IDENTIFYING INFORMATION

License #:	AS190414436
Investigation #:	2026A1033006
Complaint Receipt Date:	11/04/2025
Investigation Initiation Date:	11/05/2025
Report Due Date:	01/03/2026
Licensee Name:	The Chosen Vision
Licensee Address:	13279 Audrey Lane Grand Ledge, MI 48937
Licensee Telephone #:	(517) 410-6541
Administrator:	Tina Schrump, Designee
Licensee Designee:	Tina Schrump, Designee
Name of Facility:	Chosen Vision
Facility Address:	508 Rosemont Drive Westphalia, MI 48894
Facility Telephone #:	(517) 410-6541
Original Issuance Date:	07/18/2023
License Status:	REGULAR
Effective Date:	01/18/2024
Expiration Date:	01/17/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Resident A was not provided with a proper 30-day discharge notice from licensee designee, Tina Schrump.	No
Additional Findings	Yes

III. METHODOLOGY

11/04/2025	Special Investigation Intake 2026A1033006
11/05/2025	Special Investigation Initiated - Telephone Interview conducted with Complainant, via telephone.
11/05/2025	Contact – Telephone call made Interview conducted with Guardian A1, via telephone.
11/06/2025	APS Referral No current allegations of abuse, neglect, or exploitation.
11/12/2025	Inspection Completed On-site On-site visit made to facility. There were no residents and no direct care staff members on-site.
11/12/2025	Contact - Document Sent Email correspondence sent to licensee designee, Tina Schrump, requesting resident record, facility records, pertaining to investigation.
11/13/2025	Contact - Document Received Email correspondence received from licensee designee, Tina Schrump.
11/13/2025	Contact - Telephone call made Attempt to interview Community Mental Health, case manager, Chloe Schall, via telephone. Voicemail message left, awaiting response.
11/13/2025	Contact - Telephone call made Interview conducted with direct care staff/home manager, Erica Hickcox, via telephone.

11/17/2025	Contact - Telephone call made Interview conducted with licensee designee, Tina Schrump, via telephone.
11/18/2025	Contact - Document Received Email correspondence received including requested documentation.
12/02/2025	Exit Conference Conducted via telephone on 11/17/25 and confirmed via email on 12/2/25 with licensee designee, Tina Schrump.

ALLEGATION: Resident A was not provided with a proper 30-day discharge notice from licensee designee, Tina Schrump.

INVESTIGATION:

On 11/4/25 I received an online complaint regarding the Chosen Vision, adult foster care facility (the facility). The complaint alleged that Resident A was improperly discharged from the facility on 10/8/25. On 11/5/25 I interviewed Complainant, via telephone, regarding the allegations. Complainant reported that Resident A had become aggressive at the facility with a direct care staff member and Guardian A1 was contacted to come pick up Resident A that evening. Complainant reported that Guardian A1 was under the impression that Resident A was being discharged from the facility, but Guardian A1 never received a written discharge notice for Resident A. Complainant reported that Guardian A1 would have further information regarding this situation.

On 11/5/25 I interviewed Guardian A1, via telephone, regarding the allegations. Guardian A1 reported that Resident A was fully admitted to the facility in August 2025. She reported that prior to his admission, Resident A completed several day visits and several overnight visits in attempts to transition him to the facility and the other residents. She reported that this was Resident A's first placement in an adult foster care facility and a significant transition for Resident A. Guardian A1 reported that Resident A was not only transitioning to a new living environment but also starting a new school and leaving a job he had been accustomed to working. Guardian A1 reported that Resident A did have some behavioral outbursts at the facility during his transitional period. She reported that on 10/8/25 she received a telephone call from licensee designee, Tina Schrump, reporting that Resident A had a behavioral outburst and physically assaulted direct care staff/home manager, Erica Hickcox. Guardian A1 reported that she received this telephone call from Ms. Schrump around 5:30pm on 10/8/25 and Ms. Schrump was tearful during the conversation. She reported that Ms. Schrump stated that there had been an incident involving Resident A and Ms. Hickcox and they wanted Guardian A1 to get to the facility as soon as possible. Guardian A1 reported that Ms. Schrump stated that she did not know if Resident A was a "good fit"

for the facility. She reported that she drove the 40-minute drive to the facility and by the time she arrived, Resident A was calm and acting appropriately. She reported that it was noted Ms. Hickcox was able to administer Resident A's "PRN" medication to calm his behavioral outburst prior to Guardian A1's arrival at the facility. Guardian A1 reported that it was explained to her that the events leading up to Resident A physically assaulting Ms. Hickcox were centered around Resident A attempting to identify what vegetable could be prepared with dinner that evening. Guardian A1 was told that Resident A was fixated on figuring out what vegetable could be prepared and going through all refrigerators and freezers at the facility attempting to find vegetables. Guardian A1 reported that she was told Ms. Hickcox was attempting to encourage Resident A to come back inside the facility, as he was in the garage looking through a freezer, when Resident A became aggressive and made a motion toward Ms. Hickcox's neck as though he was going to choke her. It was then reported that Resident A grabbed Ms. Hickcox by the arm in an aggressive manner. Guardian A1 reported that she has never witnessed Resident A act out in a physically aggressive manner toward another person with intent to harm them. She reported that he does yell and runs around when upset, but has not, to her knowledge, physically assaulted someone. Guardian A1 reported that when she arrived at the facility on 10/8/25, Ms. Hickcox had packed up Resident A's medications and handed them to her. She reported that Ms. Hickcox did not state Resident A was being discharged, but Guardian A1 felt it was heavily implied that this was the course of action. Guardian A1 reported that she then asked for Resident A's bags and began to pack up his belongings. She reported that she took Resident A home with her on this date and expected there would be some communication the following day regarding the behavior and next steps. Guardian A1 reported that there was no communication from Ms. Schrump on 10/9/25. She reported that she requested a follow-up meeting on 10/10/25 with Ms. Schrump. She reported she left his request via a voicemail message. Guardian A1 reported that on 10/10/25 she did receive a telephone call from Ms. Schrump and Ms. Schrump stated that she was not sure how she could keep Resident A, the other residents, and the direct care staff members safe with Resident A at the facility. Guardian A1 reported that Ms. Schrump did not state that Resident A was being discharged but there was a lack of detailed discussion about what her statement meant regarding how to keep everyone safe. Guardian A1 reported that she did not hear back from Ms. Schrump until she requested a written discharge notice be issued. She reported that she received this written discharge notice, via email on 10/21/25. She reported that the discharge notice was dated 10/17/25 and did not clearly state that Resident A had been provided with an official discharge notice from the facility. Guardian A1 reported that when Resident A was admitted to the facility, she was not provided with a complete copy of the facility discharge policy. She reported that she was given two documents that did not appear to go together, and they were not complete documents. Guardian A1 reported that she sent email correspondence to Ms. Schrump, requesting the complete documents and did not receive these documents. She reported that she also asked Ms. Hickcox for the complete documents and was told that she had received what they had available.

On 11/6/25 I received email correspondence from Guardian A1. Guardian A1 provided documentation of communication between herself and Ms. Schrump. I reviewed the following documents:

- Email correspondence sent from Guardian A1's email address to the email address currently on file with the Department of Licensing & Regulatory Affairs, for Ms. Schrump. This correspondence was sent on 7/28/25. The third paragraph of this email reads, "[Guardian A1] was wondering whether you had provided us with the complete Chosen Vision Policies and Procedures Manual. What was in the red folder you gave me was just a couple of pages that didn't seem to belong together. (I've scanned and attached them to this email.) If you can email the complete document(s) to me, that would be great."
- *Policies And Procedures Manual*, for Chosen Vision, *Subject*, *Resident Discharge Process*. This two-page document is the documentation Guardian A1 stated she received upon Resident A's admission to the facility.
    - This two-page document is identified with page numbers 1 and 2, but the two pages do not align with content. Page one ends with bullet point 9 and page two begins with bullet point 5. These two pages both include information about resident discharge, but it does not read in a cohesive manner and several aspects related to an emergency discharge are absent from this document.
- Email correspondence sent from Ms. Schrump to Guardian A1, dated 10/21/25. This email contained an attachment with the discharge letter for Resident A but did not have any text in the body of the email.
- A formal letter from Chosen Vision, addressed to Guardian A1 and A2, dated 10/17/25. This letter dictated the following: "On October 8th, 2025 I contacted you to pick [Resident A] up from the home due to behavioral outbursts and physical aggression towards a staff member. I also said, "I am not sure that Chosen Vision is the right place for [Resident A]" when we were on the phone. When you picked him up that evening you took some of his belongings and all his medications. On Friday you returned to the home and took all of [Resident A's] belongings except his bed, bike, and dresser. We spoke after you removed his belongings. [Resident A's] disruptive outbursts at the home caused concerns for the staff and resident's safety. These behaviors include, running through the home slamming doors, standing on the counters, spitting, and hitting. This has created an unhealthy home environment for the residents. Chosen Vision works diligently to ensure our homes are a safe environment for our residents and staff. We hope that [Resident A] can find placement that better fits his needs and provides the environment that [Resident A] can thrive in. Tina Schrump and Chosen Vision Board of Directors." This document is not signed with either a written or electronic signature.

On 11/12/25 I attempted to conduct an unannounced, on-site investigation at the facility. I arrived at the facility and there were no residents or direct care staff members on-site at the time of my arrival.

On 11/12/25 I sent email correspondence to Ms. Schrump requesting documents from Resident A's resident record. Ms. Schrump responded to this email correspondence and provided the requested documentation on 11/13/25. I reviewed the following documents:

- *Assessment Plan for AFC Residents*, document for Resident A, dated 7/27/25. On page one, under section, *I. Social/Behavioral Assessment*, subsection, *B. Communicates Needs*, the document is marked "Yes", and reads, "Needs support to communicate more complex needs (ex. Trouble shooting electronic devices)". Under subsection, *I. Controls Aggressive Behavior*, the document is marked "Yes", and reads, "Will demonstrate precursor behaviors as a warning of potential for escalation."
- A document was included with a list of dates that incident reports were filed with Clinton Eaton Ingham Community Mental Health. The recorded incidents were initialed with *Staff Initials,* "EH". The dates listed are as follows:
    - 5/2/25
    - 5/29/25
    - 6/6/25
    - 6/26/25
    - 8/11/25
    - 8/11/25
    - 8/12/25
    - 8/12/25
    - 10/6/25
    - 10/8/25
    - 11/12/25
- A formal letter from Chosen Vision, addressed to Guardian A1 and A2, dated 10/17/25. This is the same document provided in prior email correspondence by Guardian A1.
- *Summary of Resident Rights: Discharge and Complaints* document. This document is dated 8/6/25 and signed by Guardian A1. This is a two-page document. It does not match the discharge policy document Guardian A1 provided in prior email correspondence.
- A handwritten list of Resident A's medications with the statement, "Sent home with parents on 10/8/25". This document was signed by Ms. Hickcox and Guardian A1 on 10/8/25.
- A handwritten list of Resident A's personal belongings, including resident funds, dated 10/14/25 and signed by Ms. Hickcox and Guardian A1 on this date.
- *Resident Care Agreement,* for Resident A, dated 7/29/25.
- *Resident Register.* This document lists Resident A's admission date as 8/6/25 and his discharge date as 10/9/25.
- *Treatment Plan Annual/Initial,* for Resident A, dated 9/3/25. This document was electronically signed by Clinton Eaton Ingham Community Mental Health, Chloe Schall on 9/16/25. On page one, under section, *Areas of Need*, the document reads, "The clinician has recommended the following areas be addressed in the treatment plan: Community Inclusion, Challenging Behaviors, Current Abilities, Health and Healthcare, Current Health Issues, Education, Physical Aggression

and/or Other Risk Factors." This document identifies in multiple areas that Resident A is having some trouble adjusting to the changes he has undergone, including moving into the facility and starting a new school.

On 11/14/25 Ms. Schrump sent email correspondence noting that she did not have an incident report for the event that took place with Resident A and Ms. Hickcox on 10/8/25 as this was not an incident that required documentation per the adult foster care licensing rules. She reported she did have daily log notes of the incident and did provide those for review. I reviewed the daily log notes for 10/8/25 making the following observations:

- Document completed by Ms. Hickcox noted that Resident A ate dinner around 5:07pm.
- Resident A finished dinner and became fixated on the menu for dinner on 10/9/25.
- Ms. Hickcox followed him to the garage where he was looking for a vegetable to have with dinner on 10/9/25.
- Resident A became upset, unknown why, began "screaming, slamming the freezer door, garage doors, running-big movements biting his arm".
- Ms. Hickcox followed him back into the house. Resident A was still yelling, biting arm, jumping up and down, slamming laundry room door.
- Ms. Hickcox instructed other residents to go into their bedrooms and lock their doors.
- Ms. Hickcox attempted to obtain Resident A's "PRN" medication and Resident A grabbed her by the arm. Resident A put his hand around Ms. Hickcox's collar bone and was going for her neck.
- Resident A kept Ms. Hickcox cornered for a period of 4 to 5 minutes. Resident A released Ms. Hickcox, and she was able to obtain medication for Resident A and send a message to Ms. Schrump reporting the incident.
- Ms. Hickcox locked herself in the medication room for a period of about 4 minutes and when the "slamming stopped" she took the medications out to the table and administered them to Resident A.
- The document notes, "Home admin contacted parents to come pick [Resident A] up for a few days."
- Guardian A1 and A2 arrived around 7:26pm to pick up Resident A.
- Ms. Hickcox counted and packed all medications to send home with Guardian A1 and A2.

On 11/13/25 I interviewed Ms. Hickcox via telephone regarding the allegation. Ms. Hickcox reported that Resident A was admitted to the facility on 8/6/25. She reported that prior to his admission date he completed some short day visits at the facility and a couple of overnight visits to get adjusted to the change. Ms. Hickcox reported that the direct care staff quickly realized that Resident A has a difficult time adjusting to spontaneous events or changes in a daily schedule. She reported that he would become upset if anything on the menu changed at the last minute, or even if they were on a community outing and one of the residents wanted to make an extra stop, for example, a garage sale. She reported that Resident A did not handle issues like this

very well and this would upset him. Ms. Hickcox reported that Guardian A1 did inform them about Resident A's difficulty with last minute spontaneous changes in plans and did provide them with feedback on how to address these issues. She reported that this guidance did work for a while but was not always helpful to prevent him from having a behavioral outburst. When asked about Resident A no longer residing at the facility, Ms. Hickcox reported the reasoning being, "[Guardian A1] came and picked him up." Ms. Hickcox detailed her account of the behavioral incident on 10/8/25 when Resident A became physically aggressive with her at the facility. Ms. Hickcox reported the same information that was previously viewed in the daily log notes for Resident A. Ms. Hickcox reported that when she spoke with Ms. Schrump on 10/8/25 concerning the incident, Ms. Schrump reported she would contact Guardian A1 and ask her to pick up Resident A for a couple of days. Ms. Hickcox reported that Ms. Schrump stated that she did not know if this was going to be the right placement for Resident A as she was concerned about how to keep Resident A, the other residents, and the direct care staff safe. She reported that Ms. Schrump indicated she was going to arrange a meeting to discuss options for Resident A's future at the facility. Ms. Hickcox reported that Guardian A1 arrived at the facility on 10/8/25, took Resident A, his medications, and some of his belongings and left the facility. Ms. Hickcox reported that she did text Guardian A1 on 10/9/25 to remind her that Resident A had been taking an antianxiety medication before he attends school in the mornings. She reported that she did not discuss discharge with Guardian A1 and did not confirm with Guardian A1 whether Resident A would be returning to the facility. Ms. Hickcox reported that a couple days later, Guardian A1 coordinated to pick up the rest of Resident A's belongings and followed through with this plan.

On 11/17/25 I interviewed Ms. Schrump, via telephone, regarding the allegations. Ms. Schrump reported that Resident A was fully admitted to the facility in August 2025. She reported that prior to his admission she had Resident A complete some day visits and a few overnight visits to become adjusted to the direct care staff and the other residents. She reported that this went on for a period of two to three months when she would have Resident A come for short visits or two-to-three-night stays at the facility. Ms. Schrump reported that Resident A was having difficulty adjusting to the facility and the lack of structure he was used to living at home. She reported that this was his first placement in an adult foster care facility and he also started at a new school at the same time. Ms. Schrump reported that she thought this was all too much too soon in terms of changes Resident A was trying to cope with and adjust to. Ms. Schrump reported that on 10/8/25 she received a voice text message from Ms. Hickcox regarding an incident with Resident A at the facility. Ms. Schrump reported that she called Ms. Hickcox back and was informed of the incident with Ms. Hickcox and Resident A concerning Resident A physically assaulting Ms. Hickcox. Ms. Schrump reported that she called Guardian A1 and spoke with her about the incident. She reported that she requested Guardian A1 go to the facility that evening to pick up Resident A and take him home for the evening. Ms. Schrump reported that she wanted to work through the situation with Resident A's community mental health case manager and behavioral specialist. She reported that she did not ask for Resident A to be discharged from the facility and had communicated that she wanted to have a meeting to discuss next steps to provide for Resident A's

needs at the facility. Ms. Schrump reported that she told Guardian A1, “I don’t know if [the facility] will be the right place for [Resident A].” She reported that she expressed concern that she is trying to figure out how to keep Resident A, the other residents, and the direct care staff members all safe. Ms. Schrump reported that part of this process was evaluating adding additional direct care staff members per shift to add supervision for Resident A. Ms. Schrump reported that she sent a text message to Guardian A1 on 10/9/25 requesting to meet to discuss the incident. She reported that on 10/8/25 Guardian A1 willingly took Resident A’s medications and some of his personal affects home with her. Ms. Schrump reported that she had a telephone conversation with Guardian A1 on 10/10/25, but Guardian A1 had already been back to the facility and removed most of Resident A’s belongings. Ms. Schrump reported that she assumed Guardian A1 had decided to move Resident A from the facility. She reported that she did not confirm this with Guardian A1 because she assumed this is what had occurred. Ms. Schrump reported, “I didn’t kick him out.” She reported that her intentions were still to work with Guardian A1 and make efforts to improve the services at the facility to better provide for Resident A’s care needs. She reported that she did not issue a standard 30-Day Discharge Notice to Guardian A1 for Resident A because she did not feel one was warranted as Guardian A1 had already decided to remove all Resident A’s belongings, on her own accord. Ms. Schrump reported that Guardian A1 had the rest of Resident A’s belongings picked up by 10/13/25. She reported that she sent Guardian A1 a final letter acknowledging Resident A’s leave from the facility but noted this was not a discharge notice as she had not intended to pursue discharge. She reported that she refunded Guardian A1 the remaining room and board payment for the month of October 2025 and returned any donation money that was made to the facility related to Resident A. Ms. Schrump reported that when Resident A was admitted to the facility, Guardian A1 signed the facility discharge policy. She reported that she cannot recall whether a copy of this policy was given to Guardian A1.

APPLICABLE RULE	
R 400.687	**Resident admission and discharge policy; house rules; change of residency; provision of resident records.**
	(4) A licensee shall provide a resident and resident's designated representative with a 30-day written notice before discharge from the facility. The notice must state the reasons for discharge and a copy of it be sent to the resident's designated representative and responsible agency. The provisions of this subrule do not preclude a licensee from providing other legal notice as required by law.

ANALYSIS:	Based upon interviews conducted with Guardian A1, Ms. Hickcox, & Ms. Schrump, as well as documentation reviewed for this investigation, there is not sufficient evidence to determine that Resident A was improperly discharged from the facility. All parties acknowledge that there was a behavioral incident concerning Resident A on 10/8/25. All parties acknowledge that Guardian A1 was contacted to pick up Resident A that evening due to the physical assault that occurred from Resident A toward Ms. Hickcox. All parties reported that Ms. Schrump stated that she was not sure the facility was the best place for Resident A and she was worried about how to keep Resident A, the other residents, and direct care staff members safe. However, Guardian A1 interpreted this communication as a request for discharging Resident A from the facility and Ms. Schrump reported that she wanted to come back together and have a conversation about how to continue to provide care for Resident A in a safe manner. Ms. Schrump reported that she took the actions of Guardian A1 moving Resident A's belongings from the facility as her notice that they would be finding a new placement for Resident A. Neither Guardian A1 nor Ms. Schrump had a direct conversation about Resident A being discharged from the facility. There appears to have been miscommunication between the two parties concerning Resident A's future at the facility. Due to this miscommunication a violation will not be established at this time.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

On 11/4/25 I received an online complaint regarding the facility. While investigating this complaint I interviewed Guardian A1 via telephone on 11/5/25. Guardian A1 reported that Resident A was fully admitted to the facility in August 2025. She reported that prior to his admission, Resident A completed several day visits and several overnight visits in attempts to transition him to the facility and the other residents. Guardian A1 reported that when Resident A was admitted to the facility, she was not provided with a complete copy of the facility discharge policy. She reported that she was given two documents that did not appear to go together, and they were not complete documents. Guardian A1 reported that she sent email correspondence to Ms. Schrump, requesting the complete documents and did not receive these documents. She reported that she also asked Ms. Hickcox for the complete documents and was told that she had received what they had available.

On 11/6/25 I received email correspondence from Guardian A1. Guardian A1 provided documentation of communication between herself and Ms. Schrump. I reviewed the following documents:

- Email correspondence sent from Guardian A1's email address to the email address currently on file with the Department of Licensing & Regulatory Affairs, for Ms. Schrump. This correspondence was sent on 7/28/25. The third paragraph of this email reads, "[Guardian A1] was wondering whether you had provided us with the complete Chosen Vision Policies and Procedures Manual. What was in the red folder you gave me was just a couple of pages that didn't seem to belong together. (I've scanned and attached them to this email.) If you can email the complete document(s) to me, that would be great."
- *Policies And Procedures Manual*, for Chosen Vision, *Subject*, *Resident Discharge Process*. This two-page document is the documentation Guardian A1 stated she received upon Resident A's admission to the facility.
    - This two-page document is identified with page numbers 1 and 2, but the two pages do not align with content. Page one ends with bullet point 9 and page two begins with bullet point 5. These two pages both include information about resident discharge, but it does not read in a cohesive manner and several aspects related to an emergency discharge are absent from this document.

On 11/12/25 I sent email correspondence to Ms. Schrump requesting documents from Resident A's resident record. Ms. Schrump responded to this email correspondence and provided the requested documentation on 11/13/25. I reviewed the following document:

- *Summary of Resident Rights: Discharge and Complaints* document. This document is dated 8/6/25 and signed by Guardian A1. This is a two-page document. It does not match the discharge policy document Guardian A1 provided in prior email correspondence.
- *Assessment Plan for AFC Residents*, document for Resident A, dated 7/27/25.
- *Resident Care Agreement,* for Resident A, dated 7/29/25.
- *Resident Register.* This document lists Resident A's admission date as 8/6/25 and his discharge date as 10/9/25.

On 11/13/25 I interviewed Ms. Hickcox via telephone regarding the allegation. Ms. Hickcox reported that Resident A was admitted to the facility on 8/6/25. She reported that prior to his admission date he completed some short day visits at the facility and a couple of overnight visits to become acclimated to the facility.

On 11/17/25 I interviewed Ms. Schrump, via telephone, regarding the allegations. Ms. Schrump reported that Resident A was fully admitted to the facility in August 2025. She reported that prior to his admission she had Resident A complete some day visits and a few overnight visits to become adjusted to the direct care staff and the other residents. She reported that this went on for a period of two to three months when she would have Resident A come for short visits or two-to-three-night stays at the facility. I asked Ms.

Schrump if Guardian A1 had received the complete discharge policy upon admission of Resident A to the facility. Ms. Schrump reported that she was not sure whether the copies of the discharge policy were given to Guardian A1.

On 11/18/25 and 11/20/25 I received email correspondence from Ms. Schrump and Ms. Hickcox. These emails provided documentation for review concerning Resident A's admission timeline to the facility. Ms. Schrump sent the following documentation for review:

- Daily log notes for Resident A. These notes identified Resident A was at the facility receiving care from direct care staff on 6/4/25, 6/7/25, 6/17/25, 6/21/25, 6/22/25, 7/9/25, 7/11/25, 7/15/25, 7/19/25, 7/20/25, 7/23/25, 7/24/25, 7/26/25, 7/27/25, & 7/29/25.
    - On 6/21/25 the daily log notes document that Resident A was administered an as needed medication due to a behavioral episode.
    - On 6/22/25 the daily log notes document that Resident A was administered his medications at 8am by direct care staff.
- *Medication Administration Record (MAR)* for the month of July 2025 for Resident A.
- No MAR sent for the month of June 2025 for Resident A.
- *Health Care Appraisal,* for Resident A, dated 7/29/25.

During email communication with Ms. Schrump, on 11/18/25, she identified that she did have the *Assessment Plan for AFC Residents* and *Resident Care Agreement* completed for Resident A, prior to his admission on 8/6/25, but she did not have Guardian A1 sign these documents until 7/27/25.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(4) A licensee, administrator, or direct care staff shall comply with the following when supervising the taking of medication by a resident: **(b) Complete an individual medication log that contains all of the following:** **(i) Medication name.** **(ii) Dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) Initials of the individual who administered the medication at the time given.** **(vi) Resident's refusal to accept prescribed medication or procedures at time of refusal.** **(c) Record the reason for each administration of medication that is prescribed on an as needed basis.**

ANALYSIS:	Based upon documentation reviewed and interviews conducted it can be determined that Resident A completed short day visits and some overnights stays at the facility prior to his admission date of 8/6/25. On 6/21/25 & 6/22/25 the direct care staff documented in a daily log note that they administered medications to Resident A, but there was not a corresponding MAR for the month of June 2025 for Resident A to document the medications administered on these dates. Therefore, a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.685	**Resident admission; resident assessment plan; resident care agreement; health care appraisal.**
	(10) A resident or resident's designated representative shall provide a written health care appraisal or a medical discharge summary by an appropriate health care professional that is completed within the 90-day period before admission. A written health care appraisal must be completed at least annually thereafter. If a written health care appraisal is not available at the time of an emergency admission, a licensee shall require that the appraisal be completed no later than 30 days after admission.
ANALYSIS:	Based upon the documentation provided by Ms. Schrump and reviewed for the purposes of this investigation, Resident A did not have a current *Health Care Appraisal* completed prior to receiving care from direct care staff members at the facility. Ms. Schrump provided daily log notes noting Resident A had multiple day visits and overnight visits in the months of June 2025 and July 2025. The *Health Care Appraisal* provided for review was dated 7/29/25, which does not fall within a 90-day period prior to the first date he received care at the facility. Therefore, a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.685	**Resident admission; resident assessment plan; resident care agreement; health care appraisal.**
	(4) A written assessment plan must be completed with and signed by the resident or the resident's designated representative, responsible agency if applicable, and the licensee at the time of admission and annually thereafter. A licensee shall maintain a copy of the resident's most recent assessment plan on file at the facility for up to 2 years after discharge.
ANALYSIS:	Based upon the documentation provided by Ms. Schrump and reviewed for the purposes of this investigation, Resident A did not have a current *Assessment Plan for AFC Residents* document completed at the time of admission to the facility. Ms. Schrump provided daily log notes noting Resident A had multiple day visits and overnight visits in the months of June 2025 and July 2025. The *Assessment Plan for AFC Residents* provided for review was dated 7/27/25. During the months of June 2025 and July 2025 an agreed upon assessment plan was not in place for Resident A's care and signed by Guardian A1. Therefore, a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

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: **(a) A statement that the facility is licensed to provide foster care to adults.** **(b) The services to be provided and the fee for those services.** **(c) Any additional costs in addition to the basic fee that is charged.** **(d) A resident's rights policy.** **(e) A discharge policy.** **(f) Transportation services provided for a basic fee and services that are provided at an extra cost.** **(g) A refund policy.** **(h) A resident's funds and valuables policy.** **(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.** **(j) An agreement by the licensee to respect and safeguard the resident's rights.** **(k) An agreement by the licensee and resident or the resident's designated representative to follow the facility's discharge policy.** **(l) An agreement by the resident, resident's designated representative, or responsible agency to provide necessary intake information, including health-related information, at the time of admission.** **(m) An agreement by the resident or the resident's designated representative to provide a current health care appraisal.** **(n) An agreement by the resident to follow written house rules if any.**

ANALYSIS:	Based upon the documentation provided by Ms. Schrump and reviewed for the purposes of this investigation, Resident A did not have a current *Resident Care Agreement* document completed at the time of admission to the facility. Ms. Schrump provided daily log notes noting Resident A had multiple day visits and overnight visits in the months of June 2025 and July 2025. The *Resident Care Agreement* provided for review was dated 7/29/25. During the months of June 2025 and July 2025 an established Resident Care Agreement was not in place for Resident A's care and signed by Guardian A1. Therefore, a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.687	**Resident admission and discharge policy; house rules; change of residency; provision of resident records.**
	(1) A licensee shall have a written admission and discharge policy and shall make it available to a resident and resident's designated representative.
ANALYSIS:	Based upon interviews conducted with Guardian A1 and Ms. Schrump, as well as review of documentation provided during this investigation, it can be determined that Guardian A1 was not provided with a complete resident discharge policy upon Resident A's admission to the facility. Guardian A1 provided documentation of email communications to Ms. Schrump, in an effort to obtain a copy of the complete discharge policy and the facility policy and procedures and was not provided with a complete comprehensive copy of this information. Therefore, a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

12/2/25

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Jana Lipps Date
Licensing Consultant

Approved By:

12/02/2025

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Dawn N. Timm Date
Area Manager