



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

January 30, 2026

Hemant Shah
Clio Memory Care, LLC
32685 Rockridge Lane
Farmington Hills, MI 48334

RE: License #: AL250384188
Investigation #: 2026A0779010
Cranberry Park Memory Of Clio

Dear Hement Shah:

Attached is the Special Investigation Report for the above referenced facility. No substantial violations were found.

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) 643-7960

Sincerely,

A handwritten signature in cursive script that reads "Christopher A. Holvey".

Christopher Holvey, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 899-5659

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL250384188
Investigation #:	2026A0779010
Complaint Receipt Date:	12/18/2025
Investigation Initiation Date:	12/18/2025
Report Due Date:	02/16/2026
Licensee Name:	Clio Memory Care, LLC
Licensee Address:	1346 W. Vienna Road Clio, MI 48420
Licensee Telephone #:	(810) 640-7783
Administrator:	Dana Pikula
Licensee Designee:	Hemant Shah
Name of Facility:	Cranberry Park Memory Of Clio
Facility Address:	1346 W. Vienna Road Clio, MI 48420
Facility Telephone #:	(810) 640-7783
Original Issuance Date:	11/14/2016
License Status:	REGULAR
Effective Date:	05/14/2025
Expiration Date:	05/13/2027
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Within the last 3 days, staff Antonae Timmons has been physically abusive to Resident A.	No
Resident B has pressure wounds from being in bed for long hours and not being turned.	No
Staff do not get Resident B up to eat or prepare her meals.	No
Staff are not following recommendations regarding Resident B's care and Resident B is constantly constipated.	Yes

III. METHODOLOGY

12/18/2025	Special Investigation Intake 2026A0779010
12/18/2025	APS Referral Complaint was received from APS.
12/18/2025	Special Investigation Initiated - Telephone Left voicemail message for APS worker.
12/19/2025	Contact - Telephone call made Spoke to Hospice nurse.
12/22/2025	Contact - Document Sent Sent email to Hospice nurse.
01/02/2026	Inspection Completed On-site
01/02/2026	Contact - Telephone call made Voicemail message left for Hospice nurse.
01/06/2026	Contact - Telephone call made Spoke to staff person, Jared Hinojosa.
01/07/2026	Contact - Face to Face Spoke to home manager.
01/08/2026	Contact - Telephone call made Spoke to staff person, Carly Stiers.
01/08/2026	Contact - Telephone call made Spoke with facility's nurse practitioner.

01/09/2026	Contact - Document Sent Second email sent to Hospice nurse.
01/09/2026	Contact - Telephone call made Voicemail left for Resident B's POA.
01/21/2026	Contact - Telephone call made Spoke to Resident B's POA.
01/21/2026	Contact - Telephone call made Spoke to Resident B's nurse practitioner.
01/29/2026	Contact - Telephone call made Spoke to administrator, Dana Pikula.
0130/2026	Exit Conference Held with administrator, Dana Pikula.

ALLEGATION:

Within the last 3 days, staff Antonae Timmons has been physically abusive to Resident A.

INVESTIGATION:

On 1/2/2026, an on-site inspection was conducted and Resident A was interviewed. Resident A claims that approximately 1-2 months ago, Staff person, Antonae Timmons, put pressure in her back while using her knuckles, during a brief change. Resident A stated that she was not injured during the incident, that there was no one else present during the incident, and that she has had no issues with Staff Timmons since. Resident A reported that Staff Timmons has been providing her with better care than ever lately. Resident A stated that all the staff have been good to her lately.

On 1/2/26, home manager, Mary Anglebrandt, stated that Resident A has a history of making false allegations against staff when she is upset. HM Anglebrandt stated that Resident A has a hard time getting along with most staff and will complain when staff provide brief and appropriate touch, when she gets upset. HM Anglebrandt reported that if staff are not able to help Resident A or complete a task right at the time Resident A requests it, Resident A gets upset and makes false statements out of frustration/anger. HM Anglebrandt reported that she remembers Resident A claiming that Staff Timmons had been rough with her, but there were no known witnesses to confirm the allegation. HM Anglebrandt stated that because of these issues, many times two staff will be present when providing Resident A to care.

On 1/2/2026, staff person, Antonae Timmons, denied that she has ever been rough with Resident A or ever used her knuckles to cause pain or discomfort to Resident A. Staff Timmons stated that Resident A is physically able to roll herself during brief changes and staff barely have to provide physical touch to get Resident A's brief changed. Staff Timmons reported that Resident A has made these types of false allegations before, so she now has another staff provide care to Resident A or have another staff present with her when she provides care. Staff Timmons stated that she would never intentionally cause pain to any resident.

During the inspection on 1/2/2026, a conversation took place with Hospice nurse, Felicia Richards, who confirmed that she provides services to Resident A. Nurse Richards stated that Resident A is a frequent complainer and finds fault with staff rather quickly when she gets upset. Nurse Richards reported that Resident A can roll herself, can physically do much more than she chooses to do, has attention seeking behavior, and then gets upset when staff don't help her fast enough or to the degree she feels she needs. Nurse Richards stated that Resident A appears to be getting good care and that she has never seen any signs that Resident A is being abused and/or neglected at this facility.

A review of Resident A's *Assessment Plan For AFC Residents* was completed. The plan confirmed that Resident A is often argumentative and plays staff against staff. It states that Resident A is bed bound by her own choice and therefore requires assistance from staff to complete her activities of daily living (ADL's). Resident A wears briefs and utilizes a wheelchair when she chooses to get out of bed.

On 1/28/2026, emails were exchanged with APS worker Jacqueline Williams, who confirmed that she investigated the same allegations. APS Williams stated that during her initial visit, Resident A refused to tell her anything and said that she wanted to "handle it" herself. APS Williams stated that she went back and visited Resident A about 30-days later and Resident A told her that things had improved and that there was no need to speak to her about it. APS Williams reported that she has closed her case without substantiating any abuse/neglect.

APPLICABLE RULE	
R 400.681	Resident rights; licensee responsibilities.
	(1) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe.
ANALYSIS:	Resident A claims that staff person, Antonae Timmons, used her knuckles to apply pressure and uncomfortable to her back and that the incident took place 1-2 months ago. Resident A stated that Staff Timmons now provides her with better care than ever and that she has no problems with Staff Timmons.

	Staff Timmons has denied ever being rough with Resident A or ever putting her knuckles into Resident A's back. It was confirmed that Resident A has a history of making false allegations when she gets upset. There were no known witnesses to the alleged incident. There was insufficient evidence to prove that Staff Timmons treated Resident A with lack of dignity or respect.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Resident B has pressure wounds from being in bed for long hours and not being turned.

INVESTIGATION:

On 12/19/2025, Nurse Beck stated that he feels that Resident B is not getting proper care. Nurse Beck stated that facility staff are not getting Resident B up and out of bed like they should and that on more than one occasion, Resident B had been left in a wet brief for up to 8-12 hours. Nurse Beck claims to know this because he asked staff to initial the briefs with date and time of changes. Nurse Beck admitted that he cannot be certain what time Resident A had urinated in the brief, but that the brief was quite wet when Hospice staff arrived and the times on the briefs were 8-12 hours earlier. Nurse Beck reported that Resident B has a pressure sore on her buttock area and a wound on her foot that they are having a hard time getting healed, due to lack of brief changes and Resident B not being repositioned frequently enough.

On 1/2/2026, an on-site inspection was conducted and home manager, Mary Anglebrandt, was interviewed. HM Anglebrandt stated that Resident B had passed away on 12/28/2025 after receiving Hospice services and being declared actively dying. HM Anglebrandt stated that they have had poor communication and have been struggling with Resident B's Hospice company. HM Anglebrandt stated that the nurses would not speak to her directly and only leave a paper document if they had new instructions for Resident B's care. HM Anglebrandt claimed that the Hospice company had multiple nurses come to treat Resident B and they would tell staff conflicting information about how they wanted Resident B cared for. HM Anglebrandt confirmed that Resident B was total care and that staff were checking on Resident B at least every two hours, which changed to every hour and then every 30 minutes as Resident B started to rapidly decline. HM Anglebrandt stated that if Resident B's brief was not wet, staff were not always changing her brief at every check, but staff were definitely repositioning her at every check. HM Anglebrandt reported that Resident B was not being left in bed all day, as staff were getting her up and into her chair for at least two hours around every mealtime. If Resident B actively resisted getting out of bed, staff

would not force her to but would make sure she was repositioned. When asked about Resident B's pressure sore, HM Anglebrandt stated that Resident B has had the wounds for several months, due to the wounds starting to heal, get worse and then start to heal again. HM Anglebrandt stated that Resident B had very thin skin and had not been eating well, so the lack of nutrition had played a role in the wounds not healing properly. HM Anglebrandt stated that the actual wound care was done by the Hospice Nurses every three or so days but insists that facility staff were keeping the wounds clean and applying creams as directed by Hospice.

On 1/2/2026, staff person, Makenzie Eidson, stated that Resident B was checked and repositioned every two hours until the last week or so, when it changed to checking her once an hour. Staff Eidson stated that if Resident B's brief was not wet, it was not always changed at each check. Staff Eidson reported that she never witnessed Resident B to be left in a wet or soiled brief for any long period of time. When asked about Resident B's wound on her buttock area, Staff Eidson stated that they always made sure it stayed clean and dry and would apply barrier cream when the dressing needed to be changed. Staff Eidson stated that Resident B's actual wound care/treatment was done by Hospice nurses during their visits. Staff Eidson reported that Resident B's wound would always fluctuate between getting better and then decline a little and so forth. Staff Eidson stated that Resident B was removed from her bed and placed in her chair at mealtimes, before being placed back into bed.

On 1/6/2026, a call was made to staff person, Jared Hinojosa, who stated that he was always assigned to Resident B's room whenever he worked, which is full-time and 12 or more-hour shifts. Staff Hinojosa confirmed that Resident B was being checked on at least every two hours and more frequently as she continued to decline toward the end of her life. Staff Hinojosa stated that every staff was not changing the brief if it was not wet during checks, but that he never witnessed Resident B wearing briefs with extended dates or times initialed on them or seen Resident B sitting in saturated briefs for long periods of time. Staff Hinojosa reported that when Resident B's dressing on her wound got wet or soiled, he would always clean the wound and apply barrier cream and a new dressing. When asked if Resident B was being left in bed, Staff Hinojosa stated that Resident B was gotten up and put into her chair during mealtimes, approximately two hours around each meal, and then placed back to bed. Staff Hinojosa stated that Resident B was turned/repositioned at every two-hour check. Staff Hinojosa reported that he last saw Resident B on 12/25/2025 and that Resident B's wound was about the size of a half dollar and had new skin forming.

Resident B's record was reviewed. Resident B was 76 years old and her assessment plan confirms that she was non-verbal, non-mobile, utilized a Geri/wheelchair and Hoyer lift, and was a 2-person assist for the majority of all her ADL's. The plan stated that Resident B wears briefs and is to be checked and/or changed every two hours.

Staff would initial Resident B's medication administration record (MAR) documenting that Resident B was being turned/repositioned every two hours. Review of Resident B's MAR confirmed that the turns/repositioning was being done consistently.

On 1/8/2026, a call was made to staff person, Carly Stiers, who stated that she worked 6:00pm-6:00am shifts and would always provide care to Resident B. Staff Stiers confirmed that Resident B was being checked every two hours and then every hour for the last week or so, before Resident B passed away. Staff Stiers stated that Resident B was turned/repositioned at every check. Staff Stiers feels that there was a period when some staff were not giving Resident B enough attention, as there were a few times that she found Resident B in wet saturated briefs, when she arrived at work at 6:00pm, but that those staff were let go and no longer work there. Staff Stiers stated that she did not work during mealtimes, but that there were times when Resident B was up in her chair when she arrived at 6:00pm. When asked about Resident B's pressure wound, Staff Stiers stated that Resident B had very thin skin and that the wound would fluctuate between being the size of a nickel and a quarter. Staff Stiers reported that she would clean the wound each shift and apply barrier cream. Staff Stiers stated that the last shift she worked around the Christmas holiday, Resident B's wound did not look bad and had new skin forming.

On 1/8/2026, a phone conversation took place with nurse practitioner, Thomas Shaefer, who confirmed that he was Resident B's primary care physician. NP Shaefer stated that Resident B was on Hospice, so he officially saw her every three months, but would put eyes on her more often when seeing other residents at this facility. NP Shaefer stated that Resident B had advanced dementia and had been bed and/or chair bound for over a year but had been in steady decline over the last six months. NP Shaefer confirmed that Resident B had sporadic eating habits, was not eating much, had gradual weight loss and had thin skin, which all resulted in her having a pressure wound. NP Shaefer stated that he last saw Resident B on 12/1/2025 and that Resident B was clean, had just eaten, and appeared to be doing well. NP Shaefer stated that Resident B's Hospice company never reported to him having any concerns regarding her care at this facility. NP Shaefer reported that he never saw anything "out of the norm" when visiting Resident B and that he had no concerns of abuse/neglect regarding Resident B's care. NP Shaefer stated that he treats multiple residents at this facility, that he is at this facility on a monthly basis and that he has no concerns regarding the care that this facility provides their residents.

On 1/21/2026, a phone call was made to Resident B's family member, who was her power of attorney (POA). When asked how often he would visit Resident B, POA stated that he worked 3rd shift, so it was difficult, and never gave a number, but stated that he would occasionally speak with Hospice nurses about Resident B's care. POA stated that he was aware that Resident B had a wound on her foot and one on her buttock area. POA stated that the foot wound started in September 2025 and that the buttock wound showed up later. POA reported that Hospice nurses would normally report that Resident B was doing well, until he received a voicemail from Nurse Beck on 12/18/2025, stating that he had concerns regarding Resident B's care, but was not specific. POA does not remember speaking with Nurse Beck regarding the specifics of his concerns. POA stated that he visited Resident B about one week before she passed and that Resident B looked very thin. POA reported that every time he visited Resident B, she was in bed and that staff told him that was to prevent her from sitting in

her chair and directly on her wound. POA stated that Hospice called him on 12/27/2025 to report that Resident B was actively dying and her body was shutting down and that Resident B passed away on 12/28/2025. POA did not provide any specific concerns that he had witnessed or had regarding Resident B's care.

On 1/21/2026, a follow-up call was made to NP Shaefer to discuss clarification regarding Resident B's wound. NP Shaefer stated that he never heard anything from Hospice regarding any concerns they had about Resident B's care at this facility, just that she had passed away. NP Shaefer stated that it was typical for the Hospice nurses to do the actual wound care and for facility staff to just keep the wound clean. NP Shaefer reported that with Resident B not eating much, her thin skin, and her not being able to move or reposition herself, it made it difficult for her wound to fully heal. NP Shaefer stated that the waxing and waning of Resident B's wound is typical for someone in her condition. He explained this is when the wound would appear to be getting better, then digress, then get better again, with this becoming a pattern. NP Scheafer stated that if neglect was taking place, the wound would get bad very quickly and stay bad.

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:	Resident B's assessment plan and MAR stated that Resident B was to be checked and turned/repositioned every two hours. Review of the MAR indicates that staff were initialing the MAR to document that this was consistently taking place. Although every staff may not have been changing Resident B's brief every two hours, if it was not wet or soiled, staff claim the two-hour checks and turns were taking place. Staff have reported that Resident B was taken out of bed and put into her chair for approximately 1-2 hours at each mealtime. Staff stated that when the wound dressing was found to be wet or soiled, the wound was cleaned and barrier cream and new dressing were applied. Up until the end of life, Resident B's wound would wax and wane, which is typical for someone in Resident B's condition. There was insufficient evidence found to prove that

	Resident B was not being provided with adequate supervision, protection and personal care.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Staff do not get Resident B up to eat or prepare her meals.

INVESTIGATION:

On 12/19/2025, a phone conversation took place with Hospice nurse, David Beck, who confirmed that his company provides services to Resident B. Nurse Beck stated that Resident B is bed-ridden, nonverbal, and requires total care from facility staff. Nurse Beck claims that facility staff are leaving Resident B in her bed during meals and not preparing a meal for her. Nurse Beck stated that, on more than one occasion, Hospice staff have been told that Resident B had not eaten, so Hospice staff have had to get Resident B out of bed, take her to the dining room and insist that the staff prepare her some food.

On 1/2/2026, HM Anglebrandt stated that staff are getting Resident B out of bed, placing her in her chair and taking her to the dining room for each meal. HM Anglebrandt stated that when Resident B resists being moved, staff are taking meals down to Resident B's room and attempting to feed her there. HM Anglebrandt reported that Resident B frequently refuses to eat, by closing her mouth or clenching her teeth, or will only eat small amounts of food. HM Anglebrandt stated that a pureed diet was put into place on 9/16/2025, after Resident B began pocketing food in her mouth and it became a choking hazard. HM Anglebrandt insisted that Resident B was always offered three meals daily and that a staff would attempt to feed her. HM Anglebrandt stated that Resident B's PCP and Hospice were fully aware of Resident B's refusal to eat and nutritional drinks were put in place to help. HM Anglebrandt reported that Hospice staff would typically come to the facility after meals had already been offered to Resident B and they would try again to get her to eat. HM Anglebrandt claimed that Hospice staff would commonly force feed Resident B, once to the point where Resident B vomited after the Hospice aide left.

Four staff were interviewed separately, but all provided the same information regarding Resident B's eating habits. All four staff stated that Resident B was brought to the dining room for each meal and that staff would attempt to feed Resident A. The staff stated that Resident B would often refuse to eat or eat very little and that Hospice was informed of this being a concern. Staff reported that nutritional drinks were eventually provided, which Resident B was more inclined to take. Staff claim that when Resident B resisted being removed from bed for meals, food was always provided to Resident B in her room.

Staff did document on Resident B's MAR that 1-on-1 feedings were attempted with Resident B for three meals daily. Some staff would record how much food Resident B would eat at meals, even though there was no physician order in place for them to do so. Sporadic documentation shows that Resident B was often only eating smaller amount of food or no food at all.

On 1/21/2026, NP Schaefer stated that he was aware of the issue with Resident B refusing meals or only eating small amounts. NP Schaefer stated that staff were reporting that Resident B was pocketing food in her mouth or simply refusing to eat and that Hospice eventually put nutritional drinks into place. NP Schaefer stated that this can be typical behavior with someone with advanced dementia and as a result, Resident B had gradual weight loss.

Resident B's weight records were reviewed. The record does show that Resident B had gradual weight loss over the last several months.

APPLICABLE RULE	
R 400.663	Nutrition; adoption by reference.
	(1) A licensee shall provide daily a minimum of 3 nutritious meals to residents.
ANALYSIS:	Staff at this facility report that Resident B was taken to the dining room for meals and when she resisted being moved, meals were taken to Resident B in her room. Staff reported that Resident B would often refuse to eat or eat only small amounts and that Hospice was fully aware of this issue. Nutritional drinks were eventually put into place that Resident B was more inclined to take. Documentation from staff shows that they were attempting 1-on-1 feedings with Resident B at three meals daily. There was insufficient evidence found to prove that Resident B was not being provided with three meals daily.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Staff are not following recommendations regarding Resident B's care and Resident B is constantly constipated.

INVESTIGATION:

On 12/19/2025, Nurse Back stated that Resident B has frequent issues with constipation. Nurse Beck feels that facility staff are not following recommendations

regarding medications, including the use of suppositories, that would help with this issue.

Multiple staff have confirmed that Resident B has issues with constipation, but stated that they have not administered any suppositories to Resident B. They stated that Hospice would administer those if needed during their visits. Staff stated that Resident B has prescribed laxative/stool softeners that she is given as prescribed.

This facility has been completing a Bowel Activity Log form for Resident B to track her bowel movement (BM's) history. A review of this log for December 2025 indicates that staff only witnessed Resident B to have three BM's for the entire month, with the last being on 12/5/2025.

A review of Resident B's MAR for December 2025 was completed. It was confirmed that Resident B was prescribed the medication Lactulose Solution 10GM/15 to be given three times daily for constipation. Records show that this medication was passed as prescribed. Resident B was prescribed Milk of Magnesia, with 30ml to be given every 72 hours. Records show that this medication was passed as prescribed. Resident B was also prescribed the medication Bisacodyl suppository 10mg that is to be inserted rectally daily as needed for constipation. Records show that this medication was not passed during the month of December 2025.

This facility has a Physician Modified Order that was provided by Hospice on 11/24/2025. That order states that Resident B was found to be constipated and the Hospice nurse had to digitally remove stool from Resident B. The order recommends that staff give Bisacodyl suppository if Resident B has no BM for three days.

A Physician Modified Order completed by Hospice Nurse Beck and dated 12/23/2025 documents concern regarding a script for Resident B for the medication Cephalexin 250/5ml. The order states that on 12/23/2025, Cephalexin was not available in the facility medication cart and the medication was sent from the pharmacy on 12/16/2025.

A review of Resident B's MAR confirms that Resident B was prescribed the medication Cephalexin on 12/16/2025 and is to be given three times daily. The first initials from staff for the medication was at 2:00pm on 12/19/2025 and state that medication was not in med cart. For the required doses of this medication for 12/20 and 12/21/2025 have initials by staff, with a note indicating the medication was not passed due to "new order- awaiting initial delivery". It appears the first dose of this medication was administered at 8:00pm on 12/21/2025.

On 1/29/2026, a conversation took place with newly appointed administrator, Dana Pikula regarding Resident B's Cephalexin medication. Admin Pikula phoned back on 1/30/2025 to confirm that a delivery form from the pharmacy shows that this medication was delivered to the facility on 12/17/2025.

On 1/30/2026, an exit conference was held with newly appointed administrator, Dana Pikula. Admin Pikula stated that she has learned that there is a need for additional training of all the staff at this facility and that process has already begun. Admin Pikula was informed of the outcome of this investigation and that a written corrective action plan is required.

APPLICABLE RULE	
R 400.689	Resident health care.
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other designated health care professional.
ANALYSIS:	Resident B has a prescription for Bisacodyl suppository that is to be used daily as needed for constipation. A Hospice nurse made the recommendation that staff administer this medication if Resident B has not had a bowel movement (BM) in three days. Documentation completed by facility staff indicates that Resident B did not have a BM from 12/6/2025 through 12/28/2025 and that the medication was not administered. It was confirmed that the medication Cephalexin was prescribed to Resident B on 12/16/2025 and delivered to the home on 12/17/2025. Records show that the first dose of Cephalexin was not administered until 8:00pm on 12/21/2025. There was sufficient evidence found to prove that this facility did not follow recommendations of a resident's physician or other designated health care professional related to two separate prescription medications.
CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION:

Staff Aubree Cook and Makenzie Eidson taunt and verbally abuse Resident C.

INVESTIGATION:

On 1/2/2026, an on-site inspection was conducted and an attempt was made to interview Resident C. Resident C has advanced dementia and very mumbled speech and did not appear to understand the questioning. She seemed to acknowledge that she gets good care and that she likes it at this home. Resident C was observed to be

clean, well-groomed and appeared to be doing well. Resident C was observed walking around the facility and frequently mumbling to herself and/or at staff.

On 1/2/2026, HM Anglebrandt confirmed that Resident A has dementia and mumbled speak and will be aggressive with staff at times, while trying to provide care. HM Anglebrandt stated that she has never witnessed any staff taunting or verbally abusing Resident C.

On 1/2/2026, staff persons, Aubree Cook and Makenzie Eidson, were interviewed separately, but provided the same information. Both staff stated that Resident C can be very aggressive toward staff. Staff Eidson stated that she will hold/hug Resident C when she gets upset and that seems to help calm her down. Staff Cook and Staff Eidson both denied that they have ever taunted or verbally abused Resident C and stated that they would never do that to any resident.

Multiple other staff were spoken to regarding the allegation of Resident C being taunted and/or verbally abused. All staff claim that they have never witnessed Staff Cook or Staff Eidson taunt, verbally abuse or disrespect Resident C.

A review of Resident C's *Assessment Plan For AFC Residents* was completed. The plan confirms that Resident C can become aggressive when stressed and has some difficulties getting along with others. It states that Resident C is mobile and requires one-person assist to complete her ADLs (Activities of Daily Living).

On 1/2/2026, Hospice Nurse Richards stated that she provides services to Resident C. Nurse Richards stated that Resident C has severe dementia and requires assistance from staff to complete all ADLs. Nurse Richards stated that Resident C has very mumbled speech but seems to understand basic communication and instructions. Nurse Richards reported that Resident C can be very feisty, aggressive, and easily agitated at times. Nurse Richards stated that all observations she has witnessed between Resident C and staff at this home have been positive and that she is not aware of any staff taunting or verbally abusing Resident C.

APPLICABLE RULE	
R 400.641	Resident behavior interventions
	(6) A licensee ,staff, volunteers, or any person who lives in the facility shall not do any of the following: (f) Subject a resident to any of the following: (ii) Verbal abuse
ANALYSIS:	Due to her advanced dementia, attempts to interview Resident C were not successful. Resident C was observed to be clean, well-groomed and appeared to be doing well. Staff persons, Aubree Cooks and Makensie Eidson, deny that they have ever

	taunted or verbally abused Resident C. Multiple other staff stated that they have never witnessed Resident C to be taunted or verbally abused. There are no known witnesses to confirm these allegations. There was insufficient evidence to prove that Resident C has been verbally abused or taunted by staff.
CONCLUSION:	VIOLATION NOT ESTABLISHED

On 1/30/2026, an exit conference was held with newly appointed administrator, Dana Pikula. Admin Pikula stated that she has learned that there is a need for additional training of all the staff at this facility and that process has already begun. Admin Pikula was informed of the outcome of this investigation and that a written corrective action plan is required.

IV. RECOMMENDATION

Upon receipt of an approved written corrective action plan, it is recommended that the status of this facility's license remains unchanged.

Christopher A. Holvey

1/30/2026

 Christopher Holvey
 Licensing Consultant

 Date

Approved By:

Mary Holton

1/30/2026

 Mary E. Holton
 Area Manager

 Date