GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

January 8, 2026

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

RE: License #:	AL740261122
Investigation #:	2026A0872007
	Mercy Village #1

Dear Sharon Cuddington:

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

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- 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) 643-7960.

Sincerely,

Susan Hutchinson, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(989) 293-5222

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL740261122
Investigation #:	2026A0872007
Complaint Receipt Date:	11/17/2025
Investigation Initiation Date:	11/17/2025
Report Due Date:	01/16/2026
Licensee Name:	Trinity Continuing Care Services
Licensee Address:	Suite 200 20555 Victor Parkway Livonia, MI 48152
Licensee Telephone #:	(810) 989-7492
Administrator:	Crystal Campagne
Licensee Designee:	Sharon Cuddington
Name of Facility:	Mercy Village #1
Facility Address:	4170 24th Ave Fort Gratiot, MI 48059
Facility Telephone #:	(810) 989-7440
Original Issuance Date:	04/28/2005
License Status:	REGULAR
Effective Date:	05/21/2024
Expiration Date:	05/20/2026
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Staff Aaron Williams sleeps during his shift.	No
On the morning of 11/13/2025, one resident was covered in dried feces from Staff Williams not attending to her needs.	Yes

III. METHODOLOGY

11/17/2025	Special Investigation Intake 2026A0872007
11/17/2025	APS Referral This complaint was referred by APS but was not assigned for investigation
11/17/2025	Contact - Document Sent I emailed the APS supervisor requesting information about this complaint
11/17/2025	Special Investigation Initiated - Letter
12/09/2025	Inspection Completed On-site Unannounced
12/09/2025	Contact - Document Sent I emailed the administrator requesting information related to this complaint
12/12/2025	Contact - Document Received AFC documentation received
01/06/2026	Contact - Telephone call made I interviewed Guardian A1
01/07/2026	Contact - Telephone call made I interviewed staff Dominique Varilone
01/07/2026	Contact - Telephone call made I interviewed staff Samantha Sanchez

01/07/2026	Exit Conference I conducted an exit conference with Crystal Campagne
01/07/2026	Inspection Completed-BCAL Sub. Compliance

ALLEGATION: Staff Aaron Williams sleeps during his shift.

INVESTIGATION: On 12/09/2025, I conducted an unannounced onsite inspection of Mercy Village #1 Adult Foster Care facility. I interviewed the administrator (AD), Crystal Campagne and the nurse manager, Shawna Ballor. I also interviewed Resident B and Resident C, and I observed Resident A.

I reviewed the allegations with AD Campagne, and she confirmed that she received and investigated a complaint alleging that staff Aaron Williams was sleeping during his shift. AD Campagne told me that this facility has three shifts and there are two staff members scheduled for each shift. All staff are to remain awake during their shift and facility policy states staff should conduct resident checks approximately once per hour.

AD Campagne stated that she investigated the allegations that Staff Williams was sleeping during his shift and she determined that during his break, Staff Williams was observed in the facility theater, lounging in one of the recliners. AD Campagne said that Staff Williams denied sleeping and since he was on break, she did not find evidence to substantiate the allegations.

I interviewed Resident B in her room. Resident B told me that she has lived at this facility for approximately 10 years and she is overall happy with the care she receives. Resident B said that she is always able to contact staff when needed and she showed me a bracelet/pendant which she presses when she needs assistance. Resident B said that she has no complaints.

I interviewed Resident C who was resting in his room. Resident C said that he has lived at this facility for approximately three months and said that the care is “excellent.” Resident C showed me a pendant that he wears around his neck and said that if he needs staff, he presses the pendant and they assist him. Resident C told me that he does not have any complaints.

On 01/06/2026, I reviewed documentation regarding this complaint. I confirmed that AD Campagne conducted an investigation regarding allegations that on 11/18/2025, Staff Williams was found sleeping in the theater room during his shift. Staff Williams was suspended pending the investigation. AD Campagne interviewed staff Williams as well as staff Deondra Sanchez and Melanie Zick. Staff Williams denied sleeping and said that he stepped into the theater room to take a phone call. AD Campagne concluded that Staff Williams was in the theater room during an authorized, covered break and there was no evidence to support that he was sleeping during his shift.

I reviewed the Resident Register and noted that as of 12/01/2025, there were 16 residents residing at this facility. I reviewed staff schedules from 11/12/2025 – 11/14/2025 and noted that there were at least two staff scheduled per shift. I also noted that scheduled staff breaks were covered by another staff.

On 01/07/2026, I interviewed staff Dominique Varilone via telephone. Staff Varilone said that she has worked at this facility for over three years and she is lead staff. I asked her if she ever found Staff Williams to be sleeping during his shift. Staff Varilone said that she never observed Staff Williams to be sleeping but she did observe him to be on his phone while he was supposed to be working. Staff Varilone said that there are always at least two staff on shift. She said that staff Aaron Williams is no longer working for this facility.

I attempted to contact staff Aaron Williams on multiple occasions. As of 01/07/2026, he has not returned my phone calls.

On 01/07/2026, I spoke to AD Campagne who stated that staff Aaron Williams is no longer working for their facility.

APPLICABLE RULE	
R 400.633	**Staffing requirements.**
	(1) A licensee shall always have sufficient direct care staff on duty for the supervision, personal care, and protection of residents and to provide the services specified in a resident's assessment plan, health care appraisal, and resident care agreement. At a minimum, the ratio of direct care staff to residents must not be less than 1 direct care staff to either of the following: **(a) 15 residents during waking hours or 20 residents during sleeping hours for large group homes and congregate facilities.**
ANALYSIS:	AD Campagne said that she conducted an internal investigation and did not find evidence to substantiate allegations that staff Aaron Williams was sleeping during his shift. Staff Dominique Varilone said that she never observed Staff Williams sleeping during his shift. I reviewed the Resident Register and determined that as of 12/01/25, there were 16 residents at this facility. I reviewed staff schedules for a period of three days and noted that there were at least two staff scheduled per shift. In addition, scheduled staff breaks were covered by other staff.

	As of 01/07/26, former staff Aaron Williams has not returned my calls. I conclude that there is insufficient evidence to substantiate this rule violation at this time.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: On the morning of 11/13/2025, one resident was covered in dried feces from Staff Williams not attending to her needs.

INVESTIGATION: On 12/09/2025, I conducted an unannounced onsite inspection of Mercy Village #1 Adult Foster Care facility. I interviewed the administrator (AD), Crystal Campagne and the nurse manager, Shawna Ballor. I also interviewed Resident B and Resident C, and I observed Resident A.

I reviewed the allegations with AD Campagne, and she confirmed that she received and investigated a complaint alleging that Resident A had feces on her person and on the floor in her room because Staff Williams had not changed her as he was supposed to. I asked AD Campagne and NM Ballor if Resident A has any rashes or skin breakdown that could be a result of sitting in a soiled brief and they said no.

AD Campagne told me that this facility has three shifts and there are two staff members scheduled for each shift. All staff are to remain awake during their shift and facility policy states staff should conduct resident checks approximately once per hour.

AD Campagne said that the allegations regarding Resident A were alleged on the evening of 11/12/2025. AD Campagne said that on that date, incoming staff alleged that she found Resident A in a feces soiled brief and there was feces on the floor in her room. This staff alleged that Staff Williams oversaw Resident A during that time and he did not attend to her personal care as he should have. AD Campagne said that as a result of that investigation, staff were reprimanded for not correctly following procedures regarding walking rounds, but she was unable to substantiate Resident A having a soiled brief and feces on her floor. Resident A currently receives hospice care.

Resident A was in her bedroom, sleeping at the time of my investigation, so I was unable to interview her. Resident A receives hospice services, and she is minimally communicative. I observed her and her room to be clean with no malodorous odor. Her clothing also appeared clean as well as her bathroom.

I conducted a visual inspection of several other rooms in the facility and found all rooms to be clean with no malodorous odor. I interviewed Resident B in her room. I found her to be clean, dressed appropriately and appropriately supervised by staff. Resident B told me that she has lived at this facility for approximately 10 years and she is overall

happy with the care she receives. Resident B told me that she does not require staff assistance with toileting, but she does receive staff assistance with bathing. Resident B said that she is always able to contact staff when needed and she showed me a bracelet/pendant which she presses when she needs assistance. Resident B said that she has no complaints.

I interviewed Resident C who was resting in his room. Resident C was clean, dressed appropriately, and was appropriately supervised by staff. Resident C said that he has lived at this facility for approximately three months and said that the care is “excellent.” Resident C told me that he does not need staff assistance with toileting, but he does receive staff assistance with bathing. Resident C showed me a pendant that he wears around his neck and said that if he needs staff, he presses the pendant and they assist him. Resident C told me that he does not have any complaints.

I reviewed the investigation summary completed by AD Campagne regarding Resident A. According to this report, on 11/13/2025 at approximately 2:10am, staff reported finding Resident A with feces on her person and dried feces in her bathroom. AD Campagne interviewed staff Samantha Sanchez, Dominique Varilone, and Aaron Williams. Staff Sanchez reported that when she entered Resident A’s room at approximately 2:10am, she observed dried feces on her person and in her bathroom. Staff Sanchez called for assistance and proceeded to shower Resident A.

Staff Varilone confirmed that on 11/13/2025 at approximately 2:10am, she observed Resident A with feces on her back and bottom, as well as dried feces in her bathroom. Staff Varilone cleaned Resident A’s bedroom while Staff Sanchez showered Resident A.

Staff Williams told AD Campagne that he provided personal care to all residents during his shift as required. Staff Williams said that he last completed resident checks at 1:00am and provided personal care including changing briefs of any residents who needed it. Staff Williams reported that he did not observe any concern regarding Resident A having a BM at that time. AD Campagne reviewed Resident A’s care log which stated that Staff Williams last checked on her at 1:00am. Since Resident A was checked again at 2:10am, she was checked according to facility policy. AD Campagne did not substantiate the allegations.

On 01/06/2026, I interviewed Guardian A1 via telephone. Guardian A1 said that Resident A resided at this facility for approximately five years and she passed away under hospice care on 12/13/2025. According to Guardian A1, he visited with Resident A on a weekly basis, and he never had any concerns about the care or treatment she received by staff. Guardian A1 said that he feels staff provided good care to Resident A while she resided at Mercy Village #1.

On 01/07/2026, I interviewed staff Dominique Varilone via telephone. Staff Varilone said that she has worked at this facility for over three years and she is lead staff. Staff Varilone stated that on 11/13/2025 at approximately 2am, staff Samantha Sanchez

called to tell her that Resident A was covered in feces and she needed assistance. According to Staff Varilone, when she entered Resident A's room, she found her covered in dried feces. Staff Varilone said that Resident A's brief was extremely full and was falling off. It had dried feces in it and Resident A had dried feces all over her bottom, her back, and her legs. Resident A also had dried feces on her bedroom floor, her bathroom floor, and the walls by her bed. I asked Staff Varilone if it was possible that Resident A had just recently had a bowel movement and she said no. Staff Varilone told me that Resident A's condition was not a result of a fresh bowel movement, and it was obvious that she had been left in a soiled brief for hours. Staff Varilone confirmed that facility policy states that staff are to check on the residents at least every hour. According to Staff Varilone, staff Aaron Williams was the staff who was in charge of Resident A prior to staff Sanchez discovering her condition.

On 01/07/2026, I interviewed staff Samantha Sanchez via telephone. Staff Sanchez said that she has worked at this facility since late October 2025 and she typically works the day shift. Staff Sanchez confirmed that on 11/13/2025, she arrived for work at approximately 2am and conducted rounds with outgoing staff, Aaron Williams. Staff Sanchez said that she looked in Resident A's room while with Staff Williams, but she did not check Resident A's brief at that time.

According to Staff Sanchez, after Staff Williams left, she went into Resident A's room and noticed dried feces all over her bedroom floor. Staff Sanchez went into Resident A's bathroom and found dried feces on the floor, on the toilet, and on the toilet handle. She immediately went to Resident A and uncovered her, seeing that she was covered in dried feces. Staff Sanchez said that Resident A's brief was sagging, almost to her knees and it was full of urine and dried feces. Resident A's bedding was also covered in dried feces and there was dried feces on the wall by her bed. I asked Staff Sanchez if it was possible that Resident A had just had a bowel movement, and she said no. Staff Sanchez told me that based on the condition of Resident A, it was apparent that her brief had not been changed in several hours. Staff Sanchez stated that she asked Staff Varilone for assistance and Resident A was showered and her room was cleaned.

I reviewed the staff schedule for 11/12/2025 – 11/14/2025. According to the schedule, staff Aaron Williams was working on 11/12/2025 until 2am on 11/13/2025. I reviewed paperwork related to Resident A. Resident A was admitted to Mercy Village #1 on 02/18/2021. According to her Assessment Plan, regarding toileting, "Staff to assist as needed. Staff to ensure resident has a clean dry brief on."

I attempted to contact staff Aaron Williams on multiple occasions. As of 01/08/2026, Staff Williams has not returned my phone calls.

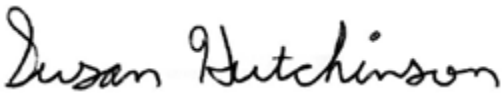
On 01/07/26, I conducted an exit conference with the administrator (AD), Crystal Campagne. I discussed the results of my investigation and explained which rule violation I am substantiating. AD Campagne confirmed that staff Aaron Williams is no

longer working for her facility. AD Campagne agreed to complete and submit a corrective action plan upon receipt of my investigation report.

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:	Staff Dominique Varilone and Samantha Sanchez stated that on 11/13/2025 at approximately 2am, Resident A was discovered with dried feces on her bottom, legs, and back. She also had dried feces on the floor in her bedroom and all over her bathroom. According to Staff Varilone, Staff Sanchez, and AD Campagne, Staff Aaron Williams was responsible for Resident A's personal care, protection, and supervision on 11/12/2025 until 2am on 11/13/2025. Staff Varilone, Staff Sanchez, and AD Campagne stated that staff are required to check on Resident A approximately once per hour. As of 01/08/2026, former staff Aaron Williams has not returned my messages and therefore, I was unable to interview him. Regarding toileting, Resident A's Assessment Plan states, "Staff to assist as needed. Staff to ensure resident has a clean dry brief on." I conclude that there is sufficient evidence to substantiate this rule violation at this time.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

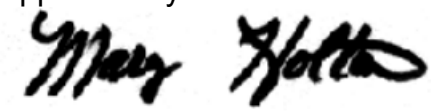
Upon the receipt of an acceptable corrective action plan, I recommend no change in the license status.



January 8, 2026

Susan Hutchinson Licensing Consultant	Date

Approved By:



January 8, 2026

Mary E. Holton Area Manager	Date