



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

February 26, 2026

Tamesha Porter
Safe Haven Assisted Living Of Mason LLC
981 Jolly Road
Okemos, MI 48864

RE: License #: AL330400202
Investigation #: 2026A1033014
Safe Haven Assisted Living Of Mason

Dear Ms. Porter:

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

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

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

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

Sincerely,

A handwritten signature in cursive script that reads "Jana Lipps". The letters are fluid and connected, with a prominent loop on the 'L' and a long tail on the 's'.

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 #:	AL330400202
Investigation #:	2026A1033014
Complaint Receipt Date:	01/22/2026
Investigation Initiation Date:	01/23/2026
Report Due Date:	03/23/2026
Licensee Name:	Safe Haven Assisted Living Of Mason LLC
Licensee Address:	981 Jolly Rd. Okemos, MI 48864
Licensee Telephone #:	(517) 402-1802
Administrator:	Tamesha Porter
Licensee Designee:	Tamesha Porter
Name of Facility:	Safe Haven Assisted Living Of Mason
Facility Address:	1850 W. Service Drive Mason, MI 48854
Facility Telephone #:	(517) 402-1802
Original Issuance Date:	05/17/2022
License Status:	REGULAR
Effective Date:	11/17/2024
Expiration Date:	11/16/2026
Capacity:	20
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Direct care staff are adjusting resident medications.	Yes
Residents are not receiving adequate personal care and hygiene. Residents are being left in soiled incontinence briefs.	No
Direct care staff, Courtney Davis and Kayla Moon, are physically and verbally abusive toward the residents.	Yes

III. METHODOLOGY

01/22/2026	Special Investigation Intake 2026A1033014
01/23/2026	Special Investigation Initiated – Telephone- Interview conducted with Adult Foster Care Licensing Consultant, Julie Elkins.
01/26/2026	Inspection Completed On-site- Interviews conducted with direct care staff/home manager, Kat Johnson, direct care staff, Graci Cole, direct care staff, Brittany Acevedo, and Resident C. Review of resident records initiated. Review of resident medications initiated. A narcotics count completed for six residents. On-site walkthrough conducted.
01/26/2026	Inspection Completed-BCAL Sub. Compliance
01/27/2026	Contact - Telephone call made- Telephone conversation with licensee designee, Tamesha Porter, regarding findings from on-site inspection.
01/27/2026	Contact - Telephone call received- Text message follow-up from Licensee Designee, Tamesha Porter, regarding status of police investigation into allegations.
01/27/2026	APS Referral- Referral made for Resident B, per protocol.
02/23/2026	Contact – Telephone call made- Interview conducted with Resident A’s medical provider, Ashley Cochran, via telephone.
02/23/2026	Contact – Telephone call made- Attempt to interview direct care staff Courtney Davis. No answer. Text message sent with request to call back. Awaiting response.

02/23/2026	Contact – Telephone call made- Interview conducted with Citizen 1, via telephone.
02/24/2026	Contact – Telephone call received- Interview conducted with direct care staff, Courtney Davis, via telephone.
02/24/2026	Exit Conference- Conducted via telephone with licensee designee, Tamesha Porter. Voicemail message left.

ALLEGATION: Direct care staff are adjusting resident medications.

INVESTIGATION:

On 1/22/26 I received an online complaint regarding Safe Haven Assisted Living of Mason, adult foster care facility (the facility). The complaint alleged that direct care staff/home manager, Kat Johnson, adjusts the narcotics counts when narcotic medications are missing. The complaint alleges that the narcotics counts are always off and Ms. Johnson will adjust the count to ensure the direct care staff do not get disciplined. On 1/22/26 I attempted contact with Complainant via email. I did not receive returned communication from Complainant.

On 1/26/26 I conducted an unannounced, on-site investigation at the facility. I interviewed Ms. Johnson regarding the allegations. Ms. Johnson reported there are currently 17 residents at the facility and ten of these residents have been ordered a narcotic for administration by direct care staff. Ms. Johnson reported that the narcotics are counted at the beginning of each shift and the end of each shift. She reported that direct care staff leaving their shift will count the narcotics with oncoming direct care staff to ensure accuracy in the number of narcotics available for each resident. She reported that these counts are noted in a narcotics count book which she was able to show me during this investigation. Ms. Johnson also reported that the narcotics are counted on the computer as another means of ensuring accuracy with the narcotics count. Ms. Johnson reported that there have been times when the narcotics count was not accurate, and the count noted less medications available than what were noted in the computer and the narcotics count book. Ms. Johnson reported that when this occurs she reviews the computer, the narcotics count book, and the narcotics on hand to verify the numbers. If the count is still off, she reported that she checks the *Medication Administration Record (MAR)* for that specific resident to ensure that direct care staff signed off for the narcotics they administered. She reported that she interviews the direct care staff working to determine whether they had administered a narcotic and just forgotten to document this administration. Ms. Johnson reported that this is the most common explanation for why the narcotics count may be off from the actual number. Ms. Johnson reported if this is the case she updates the narcotics log to provide a

notation for the administered medication that had not been signed for on the narcotics count sheet or the MAR.

During the on-site investigation on 1/26/26 I interviewed direct care staff, Graci Cole, regarding the allegations. Ms. Cole reported that she administers medications at the facility. She reported, "The narcotics count is off frequently." Ms. Cole reported that when the narcotics count does not match the actual numbers in the computer and the narcotics book, direct care staff report this to Ms. Johnson. She reported that Ms. Johnson will speak with the previous direct care staff member who administered medications, figure out why the count did not match and correct the count in the computer and the narcotics book. Ms. Cole reported that the count may not match if a direct care staff member administers a medication and forgets to sign for the administration on the narcotics book and in the computer. Ms. Cole reported that second shift has more issues with the narcotics count not matching and noted, "They are bad about completing the book", referring to the narcotics count book. Ms. Cole reported that there are two medication carts at the facility, the left and right carts, and the narcotics count is usually off for the same cart (left cart) and the same resident, and same medication. She reported she is referring to Resident A.

During the on-site investigation on 1/26/26 I interviewed direct care staff, Brittany Acevedo, regarding the allegation. Ms. Acevedo reported that she administers medications at the facility. Ms. Acevedo reported that she has observed issues with direct care staff members not signing that they had administered medications. She reported, "I think we can do better signing out meds." I inquired how Ms. Acevedo would know that a medication was administered if the direct care staff are failing to sign out the medications on the MAR. She reported that she is aware medications are administered if they are no longer in the pill packages. She reported that when she administers medications she initials and dates the pill package where the medication was taken as most of the medications at the facility are in bubble packaging. She reported that not all direct care staff members follow this procedure. Ms. Acevedo reported that the direct care staff are required to count narcotics at the beginning of their shift and the end of their shift. She reported that there have been instances where the narcotics count has been off due to direct care staff members not signing for medications that they had administered. She reported that the process is for the direct care staff to inform Ms. Johnson if the narcotics count does not match the narcotics book and the computer. She reported that Ms. Johnson will investigate the situation to determine why the count does not match. She reported that Ms. Johnson will speak with the direct care staff who administered medications on the previous shift in attempts to determine what happened and correct the narcotics count. Ms. Acevedo reported that she is not certain how to determine whether resident medications have been administered or stolen by a direct care staff member. She reported no reason to suspect a direct care staff member was stealing medication. Ms. Acevedo reported that she counted the narcotics this morning when she began her shift and the narcotics count was off for Resident A. She reported that the count was less than what the narcotics book and computer reported.

During the on-site investigation on 1/26/26 I requested to count the narcotics for Resident A, Resident B, Resident C, Resident D, Resident E, and Resident F. I conducted this narcotics count with Ms. Johnson. During the count for Resident A's medications Ms. Johnson reported that her count for the prescribed medication, Hydrocodone, was going to be off. I inquired how Ms. Johnson knew this information and she reported that the count did not match this morning during shift change. Ms. Johnson reported that direct care staff, Courtney Davis, and Ms. Acevedo counted the narcotics for Resident A this morning and reported that there were two missing Hydrocodone pills for Resident A. Ms. Johnson first reported that this information was shared with her this morning when she arrived for her shift. Ms. Johnson later reported that she thought the count may have been off over the weekend and that she thought she remembered Ms. Acevedo reporting Resident A's Hydrocodone count being off on 1/23/26. Ms. Johnson reported that she was not certain how many days Resident A's Hydrocodone count had not matched what the narcotics count book and the computer reported. Ms. Johnson reported that she had just started investigating this situation today, 1/26/26. During this investigation I reviewed Resident A's MAR for the month of January 2026. I noted to Ms. Johnson that Ms. Acevedo's name does not appear on Resident A's MAR from 1/22/26 through 1/25/26. I inquired whether Ms. Johnson knew why Ms. Acevedo would have reported the narcotics count being off for this resident on 1/23/26. Ms. Johnson reported that she was uncertain about her recollection for when Resident A's Hydrocodone was reported to have been missing two tablets. Ms. Johnson counted 20 Hydrocodone tablets for Resident A. When she entered this number into the computer the computer produced an error message noting the count should be 22 tablets. Ms. Johnson provided the written narcotics count sheet for Resident A's Hydrocodone. This document also reported there were only 20 tablets remaining as of 1/26/26 at 7:27am.

During the on-site investigation on 1/26/26 I reviewed the following documentation:

- Medication Administration Record for the month of January 2026 for Resident A. This document notes Resident A being prescribed, Hydrocodone/APAP Tab 5-325mg, take one tablet by mouth 3 times daily.
 - The MAR identifies that Resident A received the prescribed Hydrocodone medication three times per day except on 1/3/26, 1/4/26, 1/5/26. On these dates there is a notation in the computer which identified that Resident A was "physically unable to take" the medication, with a side note indicating "None in cart", "none in facility", or "none in building".
 - This medication was prescribed as a routine medication, not to be administered on an as needed basis.

On 1/27/26 I interviewed licensee designee, Tamesha Porter, via telephone, regarding the allegation. I informed Ms. Porter of the narcotics count for Resident A being off by two Hydrocodone tablets on 1/26/26 during the on-site investigation. Ms. Porter reported that she has spoken with Ms. Johnson about the issue and will be providing written disciplinary action for Ms. Johnson as the facility protocol is that direct care staff are not to leave their shift if the narcotics count is not correct. She further reported that the facility protocol would be to contact the police if there is not a proper explanation for

why the narcotics count was not accurate. Ms. Porter reported that she would be calling the police to investigate this issue.

On 2/23/26 I interviewed Citizen 1 via telephone regarding the allegation. Citizen 1 reported that they were formerly a direct care staff member at the facility. Citizen 1 reported that there were frequently issues with the narcotics count being off when they worked at the facility. They reported that Resident A's Hydrocodone count was frequently less than the narcotics book or computer noted it should be. Citizen 1 that the count was usually off when direct care staff, Courtney Davis' shift was ending. Citizen 1 reported that there were at least four times that this issue occurred on Ms. Davis' shift

On 2/23/26 I interviewed nurse practitioner, Ashley Cochran, with Optimal Care. Ms. Cochran reported that she provides care for Resident A at the facility. She reported she prescribes Resident A her Hydrocodone medication. Ms. Cochran reported Resident A has chronic pain issues and receives Hydrocodone medication three times per day, routinely. She reported that Resident A previously was prescribed Hydrocodone two times per day, but this order was updated on 10/24/25. Ms. Cochran reported that she has not been informed of Resident A's narcotics counts being off at the facility. She reported that Ms. Johnson has consistently called around the second or third of each month to request a refill on Resident A's Hydrocodone. Ms. Cochran reported, "She should never run out", referring to Resident A's Hydrocodone medication. Ms. Cochran reported that since this is a routine medication, she pushes the order through to the pharmacy and the pharmacy delivers the medication. She reported that if the medication refill is requested in a timely fashion the medication should be refilled and shipped to the facility prior to Resident A running out of medication. Ms. Cochran reported that Ms. Johnson called her office on 1/2/26 to request a refill of the Hydrocodone for Resident A. She reported that she sent the order to the pharmacy on 1/2/26. She reported that Resident A should not have been without Hydrocodone medication at the facility for administration on 1/3/26, 1/4/26, or 1/5/26. She reported that for Resident A to go three days without her Hydrocodone could cause Resident A to experience withdrawals.

On 2/24/26 I interviewed direct care staff, Courtney Davis, via telephone regarding the allegation. Ms. Davis reported that she has worked on and off at the facility for about 1.5 years. She reported that there had been a recent issue with the narcotics counts at the facility being short. Ms. Davis reported that previously the direct care staff would use a narcotics count log in a notebook and match it to the count in the computer. She reported that the narcotics were counted at the beginning and end of each shift. Ms. Davis reported that the count was frequently off and did not match what the computer noted should be available for each resident. She reported that she believes the primary reason for the count being off was due to direct care staff members not properly logging when they were giving medications to the residents. Ms. Davis reported that when the count was off the direct care staff members informed Ms. Johnson of the issue and she corrected the count in the system. Ms. Davis reported that the facility now has a new policy regarding counting narcotics. She reported that the written count logbook is no longer being utilized and the direct care staff just use the computer system to verify the

count. She reported that since this change has occurred, she has not observed one time when the count did not match what the computer noted was available for each resident. Ms. Johnson reported that the new procedure notes to contact the police, immediately, if the count does not match what the computer indicates should be available on-site. Ms. Davis reported that with this policy direct care staff members are assigned to a medication cart during their shift and are responsible for this cart. She reported that only one direct care staff is assigned to a cart during each shift. She reported that each direct care staff member holds the keys to the cart they are assigned and has their own individual login for the computer. Ms. Davis reported that she was also informed that cameras would be installed at the medication carts for additional oversight of the medication administration process.

APPLICABLE RULE	
R 400.637	Handling of resident funds and valuables.
	(11) A licensee, staff, volunteers, members of the household, and their family members cannot accept, take, or borrow money, resident funds, or valuables from a resident, even with the consent of the resident.
ANALYSIS:	Based upon the interviews conducted, the results of the narcotics count during the on-site investigation, and review of Resident A's MAR, it can be determined that Resident A is missing two Hydrocodone tablets from her monthly supply. There was not a valid, logical response for where these tablets were during the on-site investigation. Resident A's MAR indicated that she was prescribed Hydrocodone, three times daily, on a routine basis. This medication is not an as needed medication and the narcotics count should reduce by three tablets daily, if administered correctly. According to the MAR the direct care staff members initialed that Resident A received her Hydrocodone, as prescribed each day from 1/23/26 through 1/26/26, which is the time period the medication was said to be found short in the medication cart. If the medication was administered as prescribed the narcotics count should not have been missing two tablets. This medication is not an as needed medication meaning, the count should be the same number of tablets administered each day without a variance. Based upon this information a violation has been established.
CONCLUSION:	VIOLATION ESTABLISHED

APPLICABLE RULE	
R 400.675	Resident medications.
	(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.
ANALYSIS:	Based upon interviews conducted and documentation reviewed during the on-site investigation, it can be determined that Resident A did not receive her prescribed Hydrocodone medication from 1/3/26 through 1/5/26 due to the facility being out of this medication. This medication is prescribed to be administered three times per day, routinely, and the direct care staff did not have this medication refilled and available on-site for administration. Even though Ms. Cochran reported that Ms. Johnson did call for a refill request of Resident A's Hydrocodone medication on 1/2/26, Ms. Cochran noted that Resident A's prescription should never lapse. It appears that Ms. Johnson has not reached out to the provider for a refill until the medication was almost depleted at the facility, causing a lapse in administration of the medication for multiple days.
CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION: Residents are not receiving adequate personal care and hygiene. Residents are being left in soiled incontinence briefs.

INVESTIGATION:

On 1/22/26 I received an online complaint regarding the facility. The complaint alleged that residents are not receiving adequate personal care and hygiene from direct care staff members. The complaint alleged that residents are being left in soiled incontinence briefs for prolonged periods of time. On 1/22/26 I attempted contact with Complainant via email. I did not receive returned communication from Complainant.

On 1/26/26 I interviewed adult foster care licensing consultant, Julie Elkins, regarding the allegation. Ms. Elkins reported that she had conducted a recent unannounced, on-site investigation at the facility. She reported that all residents appeared to be well groomed and well cared for during her on-site visit. She reported the facility having no foul odor of urine or feces during her investigation.

On 1/26/26 I conducted an unannounced, on-site investigation at the facility at 11:30am. I interviewed Ms. Johnson regarding the allegation. Ms. Johnson reported that she has no current concerns about residents not receiving adequate personal care and hygiene support from direct care staff members. She reported that when a resident requires assistance with changing their incontinence brief it will be a task identified on the MAR.

She reported that the standard is to change each incontinent resident every two hours at a minimum. She reported that if a resident is incontinent prior to the two hour window then the direct care staff may have more times per shift than were scheduled where they provide incontinence care to a resident. Ms. Johnson reported that of the 17 current residents there are no residents who have skin integrity issues including bed sores or wounds. Ms. Johnson reported that there are some residents who are “heavy wetters” which means they urinate more frequently than another resident may. She reported that these individuals may appear to have not had their incontinence brief changed in a timely manner because it is so saturated at the scheduled changing time, but that is due to the amount of urine they produce.

During the on-site investigation on 1/26/26 I interviewed Ms. Cole regarding the allegation. Ms. Cole reported that resident personal care and hygiene needs are attended to on a regular, scheduled basis. She reported this includes before and after meals, after waking for the morning, prior to going to lay down for a nap or bedtime, and at shift changes. Ms. Cole reported that Resident B and Resident C are “heavy wetters” and need to be changed more frequently. She reported that she has seen their incontinence briefs completely saturated at times, but she cannot be sure whether the prior shift did not change them or if it is due to the amount of urine they produce. Ms. Cole reported that she is not aware of any residents having bed sores or wounds at this time.

During the on-site investigation on 1/26/26 I interviewed Ms. Acevedo regarding the allegation. Ms. Acevedo reported that incontinent residents are scheduled to receive incontinence care at a minimum of every two hours. She reported that if it is requested or found to be needed more frequently, direct care staff will modify the schedule to accommodate. Ms. Acevedo reported that there have been some concerns that the overnight direct care staff are not changing residents during the night. She reported this information from direct observations as she works first shift and thinks some of the residents have more saturated incontinence briefs when she arrives for her shift than they should. She reported that there are currently no residents with bed sores or wounds and she has no concerns about the current residents skin integrity.

During the on-site investigation on 1/26/26 I interviewed Resident G regarding the allegation. Resident G reported that she has no current concerns with the care provided to the residents by direct care staff members. She reported that the facility is kept clean and the residents are well cared for by the direct care staff. Resident G reported that direct care staff provide for resident incontinence care, hygiene, and bathing needs.

During the unannounced, on-site investigation on 1/26/26 I conducted a walkthrough of the facility. I observed the residents to be well groomed and well cared for during this visit. I did not observe any foul odors or signs of residents not having their personal care needs met on this date.

On 2/23/26 I interviewed Ms. Cochran regarding the allegation. Ms. Cochran reported that she visits the facility every other Friday between 9am and 10am. She reported that

direct care staff expect her arrival on these days. Ms. Cochran reported that she has never had a concern about the incontinence and personal care provided to the residents. Ms. Cochran reported that the facility appears clean and the residents appear clean. Ms. Cochran reported that there has been an odor of urine in some of the resident rooms at times, but she has not noticed any residents left unattended in saturated incontinence briefs for prolonged periods. Ms. Cochran reported that Resident A has recently developed a sore on her buttocks, but she is not concerned with this being related to poor hygiene at this time.

On 2/23/26 I interviewed Citizen 1 via telephone regarding the allegations. Citizen 1 reported that they had previously worked in the capacity of a direct care staff member at the facility. They reported that the direct care staff members who work on second shift (2pm to 10pm) are not providing adequate personal care and hygiene to the residents. Citizen 1 reported that residents were frequently found in completely saturated incontinence briefs on this shift. Citizen 1 reported that these concerns were reported to Ms. Johnson and no action was ever taken to address the concern.

On 2/24/26 I interviewed Ms. Elkins regarding the allegation. Ms. Elkins reported that she made two separate on-site visits to the facility in December 2025 and found no concerns regarding resident incontinence care or hygiene needs not being met. Ms. Elkins reported that the facility was clean and the residents appeared well cared for during these inspections.

On 2/24/26 I interviewed Ms. Davis via telephone regarding the allegation. Ms. Davis reported that within the past six months she has not observed any issues with residents not receiving adequate personal care and hygiene services from direct care staff members. She reported that Resident A has a sore on her backside. She reported that Resident A is the only resident at the facility who currently has a sore and this is related to Resident A refusing to get out of bed, not due to incontinence care being neglected. She reported direct care staff will reposition Resident A and she will move herself back to her backside once the direct care staff members leave the room. Ms. Davis reported that it is constant work to ensure Resident A relieves pressure from her backside.

During the on-site investigation on 1/26/26 I reviewed the following documentation:

- January 2026 MARs were reviewed for ten of the 17 residents. I observed documentation on these MARs indicating scheduled incontinence brief changes, scheduled bed linen changes. These tasks were initialed by direct care staff members as being performed at these scheduled times. On each MAR there were dates and times where initials indicating completion of the scheduled task were missing, but overall, the MARs identified consistent completion of personal care and hygiene tasks.

APPLICABLE RULE	
R 400.677	Resident hygiene, clothing.
	<p>(1) A licensee shall offer a resident appropriate opportunity, access to, and instructions for the following daily:</p> <ul style="list-style-type: none"> (a) Bathing or showering, or both. (b) Shaving. (c) Oral care. (d) Grooming. (e) Peri-care. <p>(2) A licensee shall ensure the resident receives or has access to all of the following:</p> <ul style="list-style-type: none"> (a) Bathing at least weekly. (b) Toileting as needed. (c) Assistance with resident hygiene as needed. (d) Availability of all the following resident hygiene supplies: <ul style="list-style-type: none"> (i) Deodorant. (ii) Feminine hygiene products. (iii) Razors and shaving cream. (iv) Shampoo. (v) Soap. (vi) Toothpaste. (vii) Toothbrushes. (viii) Toilet paper.
ANALYSIS:	Based upon the interviews conducted, observations made during the unannounced on-site investigation, and documentation reviewed it can be determined that there is not adequate evidence to identify that the direct care staff are not providing for the personal care and hygiene needs of the current residents. During the unannounced on-site investigation completed the residents appeared well cared for and well groomed. Ms. Elkins identified that she conducted two unannounced investigations in the month of December 2025 and had similar observations. Based on this information a violation will not be established at this time.
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Direct care staff, Courtney Davis and Kayla Moon, are physically and verbally abusive toward the residents.

INVESTIGATION:

On 1/22/26 I received an online complaint regarding the facility. The complaint alleged that Ms. Davis will slap Resident B when he becomes upset or gets agitated. The

complaint further reported that direct care staff, Kayla Moon, yells and uses obscenities toward the residents. On 1/22/26 I attempted contact with Complainant via email. I did not receive returned communication from Complainant.

On 1/26/26 I conducted an unannounced, on-site investigation at the facility. I interviewed Ms. Johnson regarding the allegations. Ms. Johnson reported that she has no direct knowledge of Ms. Davis slapping Resident B. She reported no direct knowledge of Ms. Moon yelling and using obscenities toward the residents. Ms. Johnson reported that there are times when the direct care staff will need to elevate the level of their voice to accommodate residents who are hard of hearing.

During the unannounced, on-site investigation on 1/26/26 I interviewed Ms. Cole regarding the allegation. Ms. Cole reported that she has no direct knowledge of direct care staff members yelling at residents, speaking to residents in a derogatory manner, or using physical force with residents. Ms. Cole reported to knowledge of a direct care staff member slapping a resident.

During the unannounced, on-site investigation on 1/26/26 I interviewed Ms. Acevedo regarding the allegation. Ms. Acevedo reported that she has no direct knowledge of direct care staff members yelling at residents or speaking with residents in a derogatory manner. She reported that she has observed direct care staff raise their voices when communicating with residents who are hard of hearing. Ms. Acevedo reported that she did hear from Ms. Cole that a direct care staff member had slapped Resident B in the hand, but she had no direct knowledge of this alleged incident.

During the unannounced, on-site investigation on 1/26/26 I interviewed Resident G regarding the allegation. Resident G reported no direct knowledge of any direct care staff members yelling at residents, speaking with residents in a derogatory manner, or physically harming residents.

During the unannounced, on-site investigation on 1/26/26 I reviewed the following documentation:

- January 2026 *MAR* for Resident B. Under section, *Diagnosis & Comments*, some of the diagnoses listed were:
 - Dementia
 - Senile degeneration of the brain
 - Hallucinations

On 2/23/26 I interviewed Citizen 1, via telephone, regarding the allegation. Citizen 1 reported that they were told by Ms. Acevedo that Ms. Davis slapped Resident B. Citizen 1 did not know the date or how many instances this alleged behavior occurred. Citizen 1 reported that they had observed Ms. Moon yelling at direct care staff and residents. Citizen 1 reported that Ms. Moon has used the word “retarded” when referring to her peers at the facility.

On 2/23/26 I interviewed Ms. Cochran via telephone regarding the allegation. Ms. Cochran reported that she has no direct knowledge of direct care staff members yelling at residents, using derogatory comments toward residents, or physically harming any of the residents.

On 2/24/26 I interviewed Ms. Davis, via telephone, regarding the allegation. Ms. Davis reported that she wanted to tell the truth and stated, "I did smack [Resident B]". I asked for clarification regarding this statement. Ms. Davis reported that she and direct care staff, Ryley Elieff, were providing care to Resident B and Resident B grabbed Ms. Elieff's arm and began twisting his hands on her forearm. Ms. Davis reported that Resident B would not release Ms. Elieff's arm and she "smacked him". She reported that she did this and told Resident B that he needed to respect the direct care staff members and found his behavior unacceptable. Ms. Davis reported that she felt this act of slapping Resident B's hand was justified and reported that she was not going to sit there and pry his fingers off from Ms. Elieff's arm when she could just smack his hand to get his attention. Ms. Davis reported that she has never observed Ms. Moon speak with the residents in a derogatory manner.

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:	Based upon interviews conducted it can be determined that Ms. Davis did slap Resident B's hand while he was experiencing a behavior with Ms. Elieff. Ms. Davis admitted to this encounter and acknowledged that another option of handling the situation did not occur to her at that moment. Due to this confessed physical act toward a resident 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 current license recommended at this time.



2/24/26

Jana Lipps
Licensing Consultant

Date

Approved By:



02/26/2026

Dawn N. Timm
Area Manager

Date