GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

February 24, 2026

Cyle Pickett
Amor Memory Care Of Novi Inc.
405 W Greenlawn Ave
G11 1232
Lansing, MI 48910

RE: License #: AS630418307
Investigation #: 2026A0991008
Amor Novi

Dear Cyle Pickett:

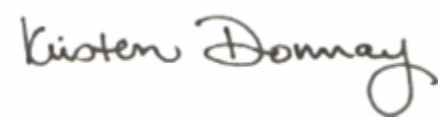
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (248) 972-9136.

Sincerely,



Kristen Donnay, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Place
3026 W. Grand Blvd. Ste 9-100
Detroit, MI 48202
(248) 296-2783

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS630418307
Investigation #:	2026A0991008
Complaint Receipt Date:	12/26/2025
Investigation Initiation Date:	12/29/2025
Report Due Date:	02/24/2026
Licensee Name:	Amor Memory Care Of Novi Inc.
Licensee Address:	405 W Greenlawn Ave G11 1232 Lansing, MI 48910
Licensee Telephone #:	(248) 536-2303
Administrator:	Cyle Pickett
Licensee Designee:	Cyle Pickett
Name of Facility:	Amor Novi
Facility Address:	41600 Borchart Dr. Novi, MI 48375
Facility Telephone #:	(248) 986-4546
Original Issuance Date:	03/18/2025
License Status:	REGULAR
Effective Date:	09/18/2025
Expiration Date:	09/17/2027
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
On 12/03/25, Resident D fell at Amor Novi. Resident D hit her head and experienced distress, but staff delayed emergency care and misreported her injuries, acting only after family intervention.	Yes
Additional Findings	Yes

III. METHODOLOGY

12/26/2025	Special Investigation Intake 2026A0991008
12/29/2025	Special Investigation Initiated - Telephone Call to complainant
12/29/2025	Contact - Telephone call made Left message for Relative 1D
12/29/2025	APS Referral Referred to Adult Protective Services (APS) - not assigned for investigation
12/30/2025	Contact - Telephone call made To licensee designee, Cyle Pickett
12/30/2025	Contact - Document Received Incident report, assessment plan, text communications, pictures of injury, verification of refund
01/04/2026	Contact - Document Received Hospital emergency department summary
01/07/2026	Contact - Telephone call received Interviewed Relative 1D
01/08/2026	Contact - Document Received Timeline of incident, hospital summary, pictures of injuries, text communications with nurse and licensee designee
01/15/2026	Inspection Completed On-site Unannounced onsite inspection
01/27/2026	Contact - Telephone call made Left message for staff, Teeah Ezell

01/27/2026	Contact - Telephone call made Interviewed nurse, Deanna Brown
01/29/2026	Contact - Telephone call made Interviewed direct care worker, Shantell (Teeah) Ezell
02/23/2026	Exit Conference Via telephone with licensee designee, Cyle Pickett

ALLEGATION:

On 12/03/25, Resident D fell at Amor Novi. Resident D hit her head and experienced distress, but staff delayed emergency care and misreported her injuries, acting only after family intervention.

INVESTIGATION:

On 12/26/25, I received a complaint alleging that on 12/03/25, Resident D fell and hit her head and that staff delayed getting medical attention for Resident D. The complaint noted that between 5:30pm-7:15pm, Resident D fell in her bedroom at Amor Novi during a caregiver assisted transfer. The facility misrepresented the severity of the fall to the family, indicating that Resident D had a “partial fall” with only an arm injury. They did not state that Resident D hit her head. The complaint noted that staff did not properly assess Resident D and delayed emergency care, despite Resident D requesting assistance and being in respiratory distress. Resident D’s oxygen level was 65%. Staff called 911 only after Resident D’s family intervened. I referred the complaint to Adult Protective Services (APS), but it was not assigned for investigation.

I initiated my investigation on 12/29/25 by contacting the complainant. The complainant stated that on 12/03/25, the nurse from Amor Novi contacted Resident A’s daughter, Relative 1D, to inform her that Resident D almost fell and had a small scrape on her arm. The complainant stated that Resident D had a knee revision and is non-weight bearing. She uses a wheelchair and requires assistance with transferring in and out of bed, as well as to and from the toilet. When the nurse contacted Relative 1D, she conveyed that Resident D had “just clipped her arm.” A short while later, Resident D’s cousin called Resident D on the phone. Resident D told the cousin that she hit her head, and nobody would help her. Resident D was very upset and scared. She was asking for assistance and requesting an ambulance. The cousin contacted Relative 1D to relay this information. Relative 1D called Resident D, who was yelling and upset. Resident D told Relative 1D that she hit her head. Relative 1D contacted the facility’s nurse, Deanna, and the licensee designee, Cyle Pickett. They stated that they did not know if Resident D hit her head or not. While this was going on, Resident D was also experiencing respiratory distress. Her oxygen level was at 65%. The complainant stated that Resident D was recently diagnosed with COPD (chronic obstructive pulmonary disease) within the last month, but her oxygen level had never been that low. At that point, Resident D was sent out to the hospital. The complainant stated that Resident D

had a bump on her head, as well as a cut on her arm, which was more than superficial. She also had a gash on her left leg. Resident D was also complaining of upper abdominal pain and was found to have three fractured ribs. The complainant stated that Resident D had only been living at Amor Novi for 36 hours when this occurred. She was hospitalized for about two weeks and did not return to Amor Novi upon her discharge.

On 01/07/26, I interviewed Relative 1D. Relative 1D stated that on 12/03/25, she was at Amor Novi around 4:24pm, dropping off some things for Resident D. Resident D was doing well. Relative 1D left shortly before 5:00pm. At 7:16pm, she received a call from Deanna, the facility's nurse, who stated that Resident D had a partial fall when staff was taking her to the commode, and scraped her arm. Deanna stated that everything was fine, but Resident D had a skin tear. Deanna stated that Resident D was getting settled back into her room. At 8:16pm, Relative 1D received a phone call from Resident D's cousin who stated that she should call Resident D, because Resident D was upset and said that she hit her head and hurt her leg. Relative 1D stated that she called Resident D at 8:23pm and could hear that she was hysterical. She was wheezing and could not breathe. Resident D told Relative 1D that staff were refusing to call an ambulance and were refusing to help her. Relative 1D stated that Resident D's breathing sounded like it was getting worse. She called the home's nurse, Deanna, and left a voicemail message. She then sent a text message to the group chat that included Deanna and the licensee designee, Cyle Pickett. She told the group that she spoke with Resident D and Resident D was pretty hysterical about the fall. Resident D mentioned hitting her head and leg. Deanna responded that she would talk to the caregiver who was on shift. Relative 1D received a return call from Deanna at 8:36pm. Deanna told her that the caregiver took Resident D's vitals and her oxygen was down to 65%, so they decided to call an ambulance. At 8:54pm, Deanna called Relative 1D to advise that Resident D was transported to Providence Hospital in Novi wearing a rebreather oxygen mask because her oxygen level was so low. Relative 1D stated that Deanna told her she confirmed with staff that Resident D did hit her head, but this had not been reported initially. Deanna was upset that this had not been reported and stated that she would investigate and get back with Relative 1D; however, Deanna never followed up again.

Relative 1D stated that when Resident D went to the hospital, they found that Resident D had a lump on her head. They did a CT scan and found she had an acute head injury. They did a CT scan on her ribs later and found that she had a mild fracture of ribs five through seven. Relative 1D stated that Resident D did not have any previous injuries to her ribs. Relative 1D stated that she was not sure how the fall happened. Resident D is non-weight bearing. She has a spacer in her right knee, as she had a knee replacement that got infected. She requires assistance to stand and pivot for transfers. Relative 1D stated that she noticed Resident D had spilled water on the floor of her bedroom when she was visiting earlier that day. Staff did not clean it up while she was there. She was unsure if this contributed to the fall. She stated that the call button was also broken in Resident D's room. Relative 1D stated that Resident D only resided at Amor Novi for 36 hours. They moved her to a different placement after she was discharged from the hospital. She is doing well in her new placement. Resident D's recall of the events surrounding her fall is not very clear.

On 01/15/26, I conducted an unannounced onsite inspection at Amor Novi. I interviewed direct care worker, Ebony Blanding. Ms. Blanding stated that she did not work during the two days that Resident D was residing in the home, and she did not have any information regarding Resident D's fall. She stated that if a resident falls, staff complete an incident report and contact the nurse, Deanna Brown. She stated that they typically make a decision with the nurse as to whether or not a resident should be sent out to the hospital. She stated that if a resident had a bruise or laceration, she would send them to the hospital as a precaution.

On 01/27/26, I interviewed the nurse consultant for Amor Novi, Deanna Brown, via telephone. Ms. Brown stated that caregivers are supposed to call her whenever a resident experiences a fall. On 12/03/25, she received a call from the staff on shift, Teeah, regarding Resident D's fall. Teeah reported that Resident D was being assisted to the bathroom when she became weak. She began to fall, and staff cradled her as she slid down. Teeah told Ms. Brown that Resident D had a skin tear on her arm. She did not explain how the skin tear happened. Ms. Brown stated that her understanding was that Resident D did not hit anything and there was no big impact from the fall. Staff did not indicate that Resident D hit her head. Her vitals were fine. Teeah took Resident D to the kitchen table after the fall. She told Ms. Brown that Resident D ate dinner and went back to bed because she was not feeling well. Ms. Brown stated that she received a call from Relative 1D a couple hours after the initial fall, stating that Resident D hit her head. Ms. Brown called Teeah, who stated that she did not remember Resident D hitting her head. Teeah reported that Resident D was not feeling well and her oxygen level was low. Ms. Brown walked her through putting Resident D's oxygen on. Resident D was struggling to breathe, and her oxygen level was in the 80s while she was receiving oxygen. They decided to send Resident D to the hospital because she was desaturating. Ms. Brown stated that the determination to send Resident D to the hospital was because her oxygen levels were low and was not directly related to her falling earlier. She stated that she did not know if the two events were related, and she thought Resident D might have aspirated while eating dinner. She stated that at least two hours passed between the time of the fall and when Resident D was sent out to the hospital.

On 01/29/26, I interviewed Shantell (Teeah) Ezell. Ms. Ezell stated that she has worked in the home for six months. She was the only staff on shift on 12/03/25 when Resident D fell. Ms. Ezell stated that she was transferring Resident D from her bed to her wheelchair to take her to the bathroom. Resident D fell and dropped to the floor. Ms. Ezell stated that Resident D hit the floor. She did not recall seeing Resident D hit her head. Resident D had a gash on her arm from hitting the table. She stated that Resident D might have scraped her leg on the table as well. Ms. Ezell stated that she was not able to catch Resident D and she went all the way to the ground when she fell. Ms. Ezell helped her up and contacted the nurse, Deanna Brown. Ms. Brown told her to bandage Resident D's arm and leg. Ms. Ezell stated that she then took Resident D to the dining room table to eat dinner. She asked Resident D if she was in any pain, and Resident D said no. Resident D said that she was fine and nothing hurt. Resident D

seemed okay while she was eating dinner. Ms. Ezell stated that Resident D did not choke or aspirate while eating. After dinner, Resident D started complaining that she was out of breath. Resident D seemed panicky and agitated, and she kept saying that she was short of breath. Ms. Ezell reached out to the nurse, Deanna Brown, who instructed her to put Resident D on oxygen and check her vitals. Ms. Ezell could not recall what Resident D's oxygen level was at that time. She stated that Ms. Brown told her to monitor Resident D and gave her parameters. Resident D asked Ms. Ezell to call an ambulance. Ms. Ezell told Resident D to calm down, because it seemed like she was in a panic. Ms. Ezell stated that she kept telling Resident D to calm down, but Resident D could not calm down. Resident D seemed nervous and kept saying, "I can't breathe. I can't breathe." Ms. Ezell was trying to get Resident D to calm down so that she could see what was really wrong. Resident D did not say anything about the fall while she was having difficulty breathing. Ms. Ezell stated that this happened at the end of her shift. When the midnight staff, Selena, came on shift, she told her what was happening. Selena later called an ambulance, and Resident D was transported to the hospital. She was not sure what time it was when Selena called the ambulance. Ms. Ezell stated that Resident D never told her that her head hurt. She stated that it is possible that Resident D hit her head when she fell, and that she might have hit it on the table. She stated that Resident D's legs just gave out and she was not able to catch her. Ms. Ezell stated that she is trained on how to do transfers, but she might have been moving too fast when she was transferring Resident D and she could have held onto her tighter to prevent the fall.

I received and reviewed a copy of Resident D's assessment plan dated 12/01/25. It notes that Resident D is non-weight bearing on her right leg and has a wheelchair. She requires assistance with toileting, bathing, grooming, dressing, personal hygiene, walking/mobility, and stair climbing.

I received and reviewed a copy of an incident report completed by Shantell Ezell, which notes that on 12/03/25 at 5:20pm she went to help Resident D get up to go to the bathroom. Resident D slipped and fell, scratching her arm and leg. Her vitals were stable and there were no concerns. Resident D was assisted back to her chair. The incident report notes that the nurse was contacted at 5:40pm. It does not note that Resident D went to the hospital. It is unknown when the incident report was completed, as it was not signed by the licensee designee until 12/30/25.

I received and reviewed a text message that was sent from Resident D's daughter to the nurse, Deanna Brown, and licensee designee, Cyle Pickett, at 8:31pm on 12/03/25. It states, "Good evening- I received a call from my mom and she was pretty hysterical about the fall she had this evening. She mentioned hitting her head, leg and being in a lot of pain. She was asking for an ambulance and claiming that nobody would help her- when I spoke to Deanna earlier, she had said it wasn't a full fall and she only hurt her arm on the way down. I'm not sure what is fully going on or what to do…"

I received and reviewed a text message that was sent from Resident D's relative to the licensee designee, Cyle Pickett, on 12/05/25, requesting to cancel the assisted living agreement and receive a full refund. The text message notes, "Within 36 hours of admission, (Resident D) was neglected, sustained a head injury and dangerously low oxygen levels requiring hospital transport and admission. The initial report to our family stated only that she had a partial fall and 'cut her elbow,' with no mention of a head injury. A close family member who contacted (Resident D) shortly after the fall realized she was in distress, couldn't breathe, had hit her head, and that staff were refusing to call an ambulance. The family member immediately contacted me with this information and I contacted (Resident D). She was in fact in distress, voiced her head injury, that her side and leg were in pain, that she couldn't breathe and that she was being denied help or an ambulance. I immediately texted the dedicated contact group for the home to report what we had learned, and only at that point was an ambulance called and the full extent of the incident disclosed."

I reviewed a response sent by the licensee Cyle Pickett the following day. The text message notes that they are saddened that Resident D will not be returning to the facility and states, "As we know accidents do happen, we sure did not expect (Resident D) would experience a fall within her first 48 hours of admission. However after discussing further with Deanna a conversation she had directly with you (a similar incident happening at your home where (Resident D) was being assisted to bathroom by you, (Resident D) basically became dead weight, falling on you) I am no longer surprised as to why fall occurred. Something I've learned is that we will need to adjust our admission process to allow the therapy team to FIRST assess new patient for transfer status rather than trusting dc papers in their interpretation of patient transfer status ability. Just so you know in our setting it typically takes up to a month for a resident to get acclimated to our home. In this time frame, we are always working the processes and procedures to best learn care needs of clients. As part of our protocol, Deanna and I always call hospital to check in on our residents. Yesterday afternoon around 1pm, we received report from (Resident D's) assigned nurse at Providence Hospital that there is no form of head injury noted and reported (Resident D) is doing fine, vitals stable."

Relative 1D provided clarification that during initial conversations when touring Amor Novi, she mentioned Resident D's unsteadiness and that while helping her in the bathroom, Resident D lost her balance and fell against the door. Resident D did not fall on her or the ground. Relative 1D stated that due to her own health concerns and being on disability, if Resident D were to fall and become dead weight, she would not be able to do anything for her.

I received and reviewed a copy of the emergency department notes for Resident D from Henry Ford Providence Hospital. The notes indicate that Resident D was admitted on 12/03/25 at 9:27pm with the chief complaint being a fall. The notes state that Resident D was brought in by EMS (emergency medical services). She is at a nursing facility where she had a fall and hit the back of her head. This happened around 5:00-6:00pm, but they did not bring her until later when she was complaining about being short of

breath. They then called EMS to bring her in. Resident D stated that she has a history of COPD and developed increasing shortness of breath throughout the evening. She is on Eliquis. She denies any loss of consciousness, chest pain, abdominal pain, back pain, or extremity pain. She states that the only thing she injured when she fell was that she hit the back of her head. She was given a breathing treatment by EMS, which she felt helped. EMS placed her on a nonrebreather due to hypoxia. The vitals showed that Resident D's respiratory rate was 28 breaths per minute, which was noted to be high. Her oxygen saturation was 90%. The physical exam notes that Resident D was alert and oriented x 3 and was in respiratory distress. She had a contusion on the right side of the scalp. A CT scan was completed which showed no acute intracranial findings. A right parietal temporal extracranial scalp hematoma was seen. The final impressions from the emergency department note an acute head injury, acute respiratory distress, COPD exacerbation, leukocytosis, and lactic acidosis.

I received and reviewed a diagnostic imaging report for Resident D from Henry Ford Providence Hospital, which notes that an x-ray of Resident D's ribs found mildly displaced fractures involving the posterior right fifth to seventh ribs.

I received and reviewed a picture of Resident D's arm, which shows a significant laceration and bruising on her right arm. I received a reviewed a picture of Resident D's leg, which shows a large laceration on her left shin just below the knee.

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 on the information gathered through my investigation, there is sufficient information to conclude that staff did not ensure Resident D's safety and protection when Resident D fell while staff was transferring her out of her bed on 12/03/25. Resident D is non-weight bearing and requires full staff assistance for all transfers. It was initially reported that Resident D had a partial fall; however, when interviewed, the staff on shift, Shantell Ezell, stated that Resident D fully fell to the ground and she was not able to catch her. Ms. Ezell stated that she might have been moving too fast and could have held onto Resident D tighter to prevent the fall. Resident D sustained lacerations to her arm and leg, as well as a contusion on her head, and fractured ribs. The extent of the fall was not accurately reported to the facility's nurse or Resident D's family, and she did not receive medical attention until several hours after the incident.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.689	**Resident health care.**
	(3) In case of an accident or sudden adverse change in a resident's health condition, a facility shall obtain needed health care immediately.
ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that staff did not obtain needed care immediately when Resident D fell. Resident D fell at the home on 12/03/25 at 5:20pm and was not transported to the hospital until over three hours later. It was initially reported that Resident D had a “partial fall” and only sustained a skin tear on her arm. Between 8:15pm-8:30pm, family members spoke with Resident D, who was reporting that she hit her head, was in pain, and nobody would help her. Resident D’s family members observed that she was upset and appeared to be in respiratory distress. They reached out to the facility nurse, and a decision was made to call an ambulance at 8:36pm due to Resident D’s oxygen levels being low. The staff on shift, Shantell Ezell, stated that Resident D fell completely to the floor and hit her arm on the table. She stated that it was possible that Resident D also hit her head on the table. Ms. Ezell did not call an ambulance when Resident D was having trouble breathing and requesting an ambulance. She repeatedly told Resident D to calm down. She spoke to the nurse and put Resident D on oxygen. The emergency department notes indicate that Resident D had a contusion on the right side of her scalp and noted findings of an acute head injury, acute respiratory distress, COPD exacerbation, leukocytosis, and lactic acidosis. Resident D was also found to have displaced fractures involving the posterior right fifth to seventh ribs.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

During the investigation, I reviewed the staff fingerprints in the Workforce Background Check System for Amor Novi. There was no verification that fingerprinting was completed for direct care worker, Shantell Ezell. Ms. Ezell stated that she has worked at the home for six months, and she was the only staff on shift on 12/03/25 when Resident D fell.

APPLICABLE RULE	
MCL 400.734b	**Employing or contracting with certain individuals providing direct services to residents; prohibitions; criminal history check; exemptions; written consent and identification; conditional employment; use of criminal history record information; disclosure; determination of existence of national criminal history; failure to conduct criminal history check; automated fingerprint identification system database; electronic web-based system; costs; definitions.**
	(2) Except as otherwise provided in this subsection or subsection (6), an adult foster care facility shall not employ or independently contract with an individual who has direct access to residents until the adult foster care facility or staffing agency has conducted a criminal history check in compliance with this section or has received criminal history record information in compliance with subsections (3) and (11). This subsection and subsection (1) do not apply to an individual who is employed by or under contract to an adult foster care facility before April 1, 2006. On or before April 1, 2011, an individual who is exempt under this subsection and who has not been the subject of a criminal history check conducted in compliance with this section shall provide the department of state police a set of fingerprints and the department of state police shall input those fingerprints into the automated fingerprint identification system database established under subsection (14). An individual who is exempt under this subsection is not limited to working within the adult foster care facility with which he or she is employed by or under independent contract with on April 1, 2006 but may transfer to another adult foster care facility, mental health facility, or covered health facility. If an individual who is exempt under this subsection is subsequently convicted of a crime or offense described under subsection (1)(a) to (g) or found to be the subject of a substantiated finding described under subsection (1)(i) or an order or disposition described under subsection (1)(h), or is found to have been convicted of a relevant crime described under 42 USC 1320a-7(a), he or she is no longer exempt and shall be terminated from employment or denied employment.
ANALYSIS:	At the time of the investigation, there was no verification that fingerprinting was completed for direct care worker, Shantell Ezell.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION:

During my interview with Relative 1D, she stated that she requested copies of Resident D's records, including the documents that she signed at the time of Resident D's admission to the home. She requested the documents during a phone conversation with the licensee designee, Cyle Pickett, on 12/03/25. On 12/17/25, Relative 1D met with the other owner of the facility, Ash Karki, at the hospital. He provided a check that was a full refund of the amount they paid for Resident D to move into the home. They went over the incident with Ash, provided feedback, and he advised that he would provide copies of the requested documents, as well as the incident report. He did not follow up. At the time of my interview with Relative 1D on 01/07/26, she had not received any of Resident D's records that were requested.

On 02/23/26, I conducted an exit conference via telephone with the licensee designee, Cyle Pickett. Mr. Pickett was surprised to hear of the injuries that Resident D sustained following her fall at Amor Novi, as he was not aware that she had sustained any major injuries. Mr. Pickett stated that he believed Shantell Ezell had been fingerprinted and tthe requested documentation was scanned and sent to the family. He stated that he would verify this information and send documentation if these items had been completed. This documentation has not yet been received. Mr. Pickett stated that he would submit a corrective action plan and would address the issues identified during the investigation.

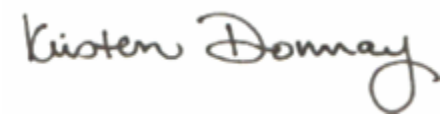
On 02/24/26, I received a follow up phone call from the licensee designee, Cyle Pickett. Mr. Pickett stated that the consulting nurse, Deanna Brown, is no longer working for the company. He confirmed that Shantell Ezell was not fingerprinted. He stated that her fingerprints are scheduled for today, and that she has been removed from the schedule until they are completed. He also verified that the requested resident documents had not been sent to Resident D's family. He stated that this was an oversight and the documents did not get sent.

APPLICABLE RULE	
R 400.687	**Resident admission and discharge policy; house rules; change of residency; provision of resident records.**
	(10) A licensee shall provide copies of resident records when requested by the resident and resident's designated representative. A fee that is charged for copies of resident records must not be more than the cost to make the copies.

ANALYSIS:	Based on the information gathered through my investigation, there is sufficient information to conclude that Resident D's records were not provided to her designated representative following multiple requests.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

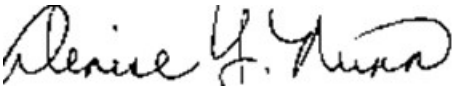
Contingent upon the receipt of an acceptable corrective action plan, I recommend no change to the status of the license.



02/23/2026

Kristen Donnay Date
Licensing Consultant

Approved By:



02/24/2026

Denise Y. Nunn Date
Area Manager