GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 9, 2026

Ira Combs, Jr.
Christ Centered Homes, Inc.
327 West Monroe Street
Jackson, MI 49202

RE: License #: AS380016315
Investigation #: 2026A0007012
Brown Street Home

Dear Mr. Combs, Jr.:

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) 284-9730.

Sincerely,

Mahtina Rubritius, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa
P.O. Box 30664
Lansing, MI 48909
(517) 262-8604

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS380016315
Investigation #:	2026A0007012
Complaint Receipt Date:	01/09/2026
Investigation Initiation Date:	01/13/2026
Report Due Date:	03/10/2026
Licensee Name:	Christ Centered Homes, Inc.
Licensee Address:	327 West Monroe Street Jackson, MI 49202
Licensee Telephone #:	(517) 499-6404
Administrator:	Ira Combs, Jr.
Licensee Designee:	Ira Combs, Jr.
Name of Facility:	Brown Street Home
Facility Address:	1203 Brown Street Jackson, MI 49203-2732
Facility Telephone #:	(517) 250-7930
Original Issuance Date:	03/24/1995
License Status:	REGULAR
Effective Date:	05/24/2024
Expiration Date:	05/23/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Between 12/31/25 and 1/1/26, there was only one direct care staff member on duty. Resident A had a fall, and staff had to call 911 to assist her with getting Resident A up off the floor. Resident B requires 1:1 supervision, and there is a concern that staff are unable to feed Resident B if there is only one direct care staff member on duty.	Yes
Resident B is underweight. Resident C lost between 16-28lbs in the last year.	No
On 1/6/26, Resident A was observed hallucinating and medical treatment was sought. Resident A was admitted into the hospital. Resident A has a bedsore. Resident B was observed with bruising around her eyes and on her head. It is unknown how the bruising occurred.	Yes

III. METHODOLOGY

01/09/2026	Special Investigation Intake- 2026A0007012
01/09/2026	Contact - Telephone call made to Rebecca Belcher, APS Worker, and Aubrey Lee, APS Worker, no answer.
01/12/2026	Contact - Document Sent - Email to Rebecca Belcher, APS Worker.
01/12/2026	Contact - Telephone call made to Guardian B1, no answer. I was unable to leave a voicemail.
01/12/2026	Contact - Document Sent - Email to Guardian B1, I requested a return phone call.
01/13/2026	Special Investigation Initiated - On Site- Unannounced – Face to face contact with Jessica Nebelung, DCW, Shy Johnson, DCW, Shatez Simpson, DCW, Resident A, Resident B, and Resident C.
01/13/2026	Contact - Face to Face - F2F with Rebecca Belcher, APS Worker.
01/20/2026	Contact - Face to Face with Rebecca Belcher, APS Worker.

02/18/2026	Contact - Telephone call made to Ashlee Griffes, ORR. Discussion.
02/18/2026	Contact - Face to Face with Rebecca Belcher, APS Worker.
02/20/2026	Contact - Telephone call made Tony Thomas, Administrative Staff.
03/03/2026	Contact - Face to Face with Rebecca Belcher, APS Worker.
03/05/2026	Contact - Document Received- Copies of ORR Reports
03/05/2026	Contact - Document Received - Email from Ashlee Griffes, ORR.
03/06/2026	Contact - Telephone call made to Jessica Neblung, no answer. Message left.
03/06/2026	Contact - Telephone call made to Janiya Broadus, (previous) DCW, no answer. Unable to leave a message.
03/06/2026	Contact - Telephone call made to Brianna Berry, Interview.
03/06/2026	APS Referral – Made.
03/06/2026	Contact – Telephone call made to Ira Combs, Licensee Designee to conduct the exit conference. No answer.
03/06/2026	Exit Conference conducted with Tony Thomas, Administrative Staff.

ALLEGATIONS:

- **Between 12/31/25 and 1/1/26, there was only one direct care staff member on duty. Resident A had a fall, and staff had to call 911 to assist her with getting Resident A up off the floor.**

- **Resident B requires 1:1 supervision, and there is a concern that staff are unable to feed Resident B if there is only one direct care staff member on duty.**

- **Resident B is underweight.**
- **Resident C lost between 16-28lbs in the last year.**

INVESTIGATION:

As a part of this investigation, I spoke with Ashlee Griffes, Office of Recipient Rights, who was also investigating the allegations. She informed me that Jessica Nebelung, who has the role of acting home manager, worked alone beginning on December 31,

2025, at 8:00 a.m. to 7:00 p.m. on January 1, 2026. During that time, Resident A had fallen and Jessica Nebelung had to contact 911 to assist with getting Resident A off the floor. Regarding Resident B, Ashlee Griffes informed me that Resident B requires 1:1 staff supervision and it is difficult for staff to assist Resident B with feeding, when there is only one staff member on duty. According to Ashlee Griffes, staff reported to Dietitian #1 that they couldn't feed Resident B if there was only one staff member on duty. There was a lack of documentation regarding the care provided. It was also reported that Resident B was underweight. In addition, Resident C lost weight; somewhere between 16lbs to 28lbs.

On January 13, 2026, I conducted an unannounced on-site investigation and made face to face contact with Jessica Nebelung, DCW, Shy Johnson, DCW, Shatez Simpson, DCW, Resident A, Resident B, and Resident C.

I observed Resident B to have a faint and small cut/scrape on the right side of her eye (right) and a scrape on her nose. When I attempted to speak to Resident B, she mumbled, and I could not understand what she was saying. Resident C was not interviewed due to his diagnoses.

I interviewed Jessica Nebelung. I inquired about the direct care staff who were on duty on December 31, 2025, and Jessica Nebelung informed me that she started on that day at 8:00 a.m. and worked until 8:00 p.m. on January 1, 2026. She stated that an employee by the name of Kaylee (last name unknown), who no longer works for CCH, was supposed to be there on 1st shift, but she was a "no show." There was also supposed to be a new employee starting on New Year's day. Janiya Broadus came to work on January 1, 2026, to cover 2nd shift (at 7:00 p.m.). During the interview, Jessica Nebelung informed me that Resident A had just returned from the hospital. Jessica Nebelung stated that Resident A is a two-person assist for transferring. Jessica Nebelung stated that on December 31, 2025, she could not get Resident A to sit upright, to get into her bed. Resident A was slouching in her wheelchair, and she couldn't assist with the brief change. On this same date, around 5:00 p.m. Nurse Laurie (last name unknown) was at the facility attempting to assist with Resident A transferring to the bed, but Resident A would not cooperate. Resident A would not sit upright. Around 1:30 a.m. Resident A yelled for help. According to Jessica Nebelung, Resident A was sitting in her wheelchair, slouched down. Jessica Nebelung told Resident A "I can't help you, if you won't help you." At 2:30 and 5:30 a.m. Resident A was observed, wide awake, still in her wheelchair. Jessica Nebelung must have dozed off and then Resident D asked, "Hey, are you going to pass meds?" Jessica Nebelung went to check on Resident A and she was face down, on the floor. Resident A said to Jessica Nebelung that she was bitten by a snake. Jessica Nebelung then had to call 911 and get assistance with getting Resident A back into bed. Jessica Nebelung stated she asked Resident A if she was alright. There was some redness on her knee but no apparent bruising.

Regarding Resident B, Jessica Nebelung informed me that she had been declining and they assist with feeding her 90% of the time. I inquired if it was a challenge to

feed Resident B if there was only one direct care staff on duty and she stated it wasn't too bad. Jessica Nebelung stated that Resident B was the only resident that required assistance with feeding.

We discussed staffing and Jessica Nebelung informed me that Resident B was supposed to see her psychiatrist on January 5, 2026, but there were only two staff at the facility and Resident B requires 2:1 while in the community. Therefore, they had to cancel the appointment.

I interviewed Resident A, who had just returned from the hospital. During the interview, I inquired if she had recently fallen or ended up on the floor, and Resident A stated that she did not remember.

As I was leaving the facility, I made face-to-face contact with Rebecca Belcher, APS Worker, who was arriving there to see Resident A. I informed her that Resident A did not report much information regarding the fall and her bedsores. Rebecca Belcher informed me that there was also a question regarding whether Resident A needed a guardian now, and she would be looking into that matter as well.

On February 20, 2026, I spoke with Tony Thomas, Administrative Staff. He stated that he had been working to address issues at this facility, and once he addressed staffing issues, then the home manager just left without notice. He stated they had a meeting and addressed the missed appointments. He's training additional staff who reside in Jackson and making sure that staff are covering the shifts. They're continuing to monitor and work and make changes at the facility.

On March 3, 2026, I made face-to-face contact with Rebecca Belcher, APS Worker. She informed me that she substantiated the allegations of neglect, as there was a lack of staffing, personal care, and follow-up, provided to Resident A, which ultimately resulted in Resident A having bedsores.

As a part of this investigation, I reviewed (three) reports from the Office of Recipient Rights. Regarding Resident A, it was noted that on January 5, 2026, it was alleged that Resident A had massive bedsores that were not being cared for (see below for additional information regarding these allegations). It was noted that ORR reviewed the staff schedule and Jessica Neblung worked from 8:00 a.m. on December 31, 2025, to 8:30 p.m. on January 1, 2026. It was noted that Shy Johnson, DCW had called in and another direct care staff member had quit. Their names were crossed off the schedule. It was also documented in the ORR investigation that ORR reviewed the *Individual Plan of Service for Resident A*, dated February 14, 2025. The plan included that by February 23, 2026, Resident A would be "assisted with repositioning every two hours to reduce her risk for development of decubitus ulcers and maintain skin integrity as evidence by 100% completion of monthly data sheets." There was only one direct care staff member on duty between December 31, 2025, and January 1, 2026.

I also reviewed the second *Office of Recipient Rights Summary Report* and the following was noted: On January 5, 2026, ORR received a complaint regarding Resident B (this information will be addressed later in this investigation). There were also concerns that the facility is short staffed and staff are unable to provide Resident B with the 1:1 staffing. ORR investigated and it was noted that the staff schedule was reviewed between December 28, 2025, and January 10, 2026. It was noted that Jessica Neblung worked several shifts, alone, for many shifts in a row between December 31, 2025, and January 1, 2026. On January 3, 2026, and January 4, 2026, Shy Johnson, DCW, worked alone during the 2nd shift, due to staff calling into work.

ORR also reviewed the *Behavior Treatment Plan* for Resident B, which documented that Resident B required 1:1 dedicated staffing (in the home), during the waking hours. Staff were to complete 15-minute bed checks while Resident B was asleep. It was also noted that Resident B had bedrails attached to her bed to assist with preventing falls, as her balance and mobility have significantly declined. ORR substantiated the allegations for Neglect Class II. CCH submitted a Corrective Action Plan, which included hiring several new employees, the home will maintain no fewer than two direct care staff on duty at all times, with one staff member specifically dedicated to the direct resident when required, staff schedules will be reviewed in advance to prevent gaps in coverage, and staff were re-educated on resident fall protocols and supervision. The expectations regarding supervision levels and safety procedures have also been clearly communicated to all team members.

I also reviewed the third *Office of Recipient Rights Summary Report* and the following, in relevant part, was noted: There was a concern regarding the diets that Resident A, Resident B, and Resident C were being provided. The data sheets were incomplete. The home has been too understaffed to appropriately feed Resident B. Resident A and Resident B have lost a concerning amount of weight in the past few months. During the investigation, ORR conducted an in-person interview with Jessica Neblung, and she reported that she did not have monthly weights available for ORR to review.

ORR later received the residents' weights and information, and the following was noted:

> Resident A weighed 190lbs in August (2025), she refused to be weighed in September and October. There was no documentation of weights for November and December of 2025. Resident A weighed 185lbs in January and 200lbs in February 2026.
>
> Resident B weighed 171lbs in August (2025), 147lbs in September, 158lbs in October, she refused to be weighed in November, 158.2lbs in December, 116lbs in January (scale was broken) and 164lbs in February of 2026.

Resident C weighed 165lbs in August (2025), he refused to be weighed in September, October, November, he weighed 165.8lbs in December, 166lbs in January, and 165.9lbs in February of 2026.

It was also noted that once the data sheets were provided, it was determined that Resident A, Resident B, and Resident C did not have concerning weight loss, and the investigation focused on the incomplete data sheets.

On March 6, 2026, I conducted the exit conference with Tony Thomas, Administrative Staff, on the behalf of Ira Combs, Licensee Designee. We discussed the investigation and my recommendations. He stated that they have made some changes to the staffing in the facility, including removing some staff. He also stated that the facility is now fully staffed, they have hired a new home manager who is in training, and they continue to monitor the home. He agreed that CCH would submit a written corrective action plan to address the established violations.

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: **(b) 12 residents for small group and family homes.**
ANALYSIS:	Based upon this investigation, which consisted of an on-site investigation, interviews with facility staff, CCH Administration, Resident A, ORR, and APS, and review of relevant information, it’s concluded that there is a preponderance of the evidence to support the allegations that there was not sufficient direct care staff on duty to provide for the supervision, personal care and protection that Resident A and Resident B required.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATIONS:

- **On January 6, 2026**, **Resident A was observed hallucinating and medical treatment was sought. Resident A was admitted into the hospital. Resident A has a bedsore.**

- **Resident B was observed with bruising around her eyes and on her head. It is unknown how the bruising occurred.**

INVESTIGATION:
As a part of this investigation, I spoke with Ashlee Griffes, ORR, and she stated that she conducted an on-site visit at the facility on Tuesday, January 6, 2026. Resident A was hallucinating, and reporting seeing her family members. The staff were encouraged to send Resident A to the hospital on that date and she was admitted. On January 13, 2026, Jessica Nebelung informed me that Resident A had just returned from the hospital. She informed me that ORR visited the facility and suggested that Resident A be seen at the hospital. Resident A was acting out of the normal and since she did not have a primary care doctor or visiting nursing, it was recommended that she go to the hospital to address the wound (bedsore on her coccyx/tailbone). Jessica Nebelung informed me that Resident A was her own person, and she had been making changes to her insurance. Once she made the changes, the primary doctor did not accept the insurance, and Resident A could not be seen by Doctor #1. Jessica Nebelung informed me that Resident A had been without a doctor or visiting nurse for at least a month. Jessica Nebelung stated that on the day that Resident A went to the hospital (January 6, 2026), they noticed a spot on her bottom and foot. They contacted the nurse and that is when the nurse told them that Resident A was no longer assigned to Doctor#1, due to Resident A changing the insurance and the doctor not accepting that insurance. Jessica Nebelung stated that Resident A has a history of refusing staff assistance or following medical recommendations, and she felt like their hands were tied because Resident A is her own person. According to Jessica Nebelung, the bedsores got worse when Resident A was in the hospital. Jessica Nebelung stated that when Resident A was (recently) discharged from the hospital, the paperwork did not describe what she was diagnosed with. Jessica Nebelung stated that Resident A was prescribed an antibiotic and referred to the wound clinic and infection control. According to Jessica Nebelung, direct care staff are to assist and reposition Resident A. However, Resident A complained that the staff were waking her up to change her brief during the night. ORR informed staff they still need to provide Resident A with the care she required. I encouraged Jessica Nebelung to contact the hospital to ensure they had all the instructions to provide Resident A with the follow-up care she required.

I interviewed Resident A, who had just returned from the hospital. Resident A informed me that she wished she could have stayed where she was (in the hospital). She stated that she had a bedsore and pointed towards her buttocks. Resident A stated that when she was in the hospital, they didn’t know that she had a bedsore.

On January 20, 2026, I made face to face contact with Rebecca Belcher, APS Worker. She reported to continue to work on Resident A’s case. Resident A signed a *Plan of Care* and would consider cooperating and participating with the assessment to determine if she needed a guardian.

On February 18, 2026, I made face to face contact with Rebecca Belcher, APS Worker. She spoke with Jessica Nebelung, who stated that they document personal care provided, such as showers, on the data sheets located in Tracking System #1. Rebecca Belcher informed me that Resident A's wound was still deep. Resident A also had a wound on the outside of her right calf. There was a prescription order for Resident A to use a pad for her wheelchair and a pressure release boot; however, Resident A is refusing to wear the boot.

On February 20, 2026, I spoke with Tony Thomas, Administrative Staff. He stated that he had been working to address issues at this facility. They're also addressing the wound care for Resident A and making sure that staff are comfortable with packing the wound and assisting with the care she requires.

On March 3, 2026, Rebecca Belcher, APS Worker, informed me that she substantiated the allegations of neglect, as there was a lack of staffing, personal care, and follow-up, provided to Resident A, which ultimately resulted in Resident A having bedsores.

As a part of this investigation, I reviewed the *Office of Recipient Rights Summary Report* Regarding Resident A. It was noted that on January 5, 2026, it was alleged that Resident A had massive bedsores that were not being cared for. It was also documented in the ORR investigation that ORR reviewed the *Individual Plan of Service for Resident A*, dated February 14, 2025. The plan included that by February 23, 2026, Resident A would be "assisted with repositioning every two hours to reduce her risk for development of decubitus ulcers and maintain skin integrity as evidence by 100% completion of monthly data sheets." On January 6, 2026, ORR spoke with Resident A, and she reported that she did not feel well. It was also noted that ORR spoke with Jessica Neblung who reported that Resident A had been refusing services, which had contributed to her bedsores. Jessica Neblung informed ORR that staff realized the bedsores were getting "bad" and they tried to get Resident A in to see her doctor, however, there were barriers with her insurance, which prevented care. Jessica Neblung reported that Resident A had recently lost primary care due to an issue with her insurance. ORR reviewed the *After Visit Summary* from Hospital #1 and it was noted that Resident A was hospitalized from January 7, 2026, to January 12, 2026, for Sacral Decubitus Ulcer, Stage II. During the investigation, Employee #1 was interviewed by ORR. She informed ORR that she had worked in the facility in the past, but this facility was not her primary assignment. Employee #1 informed ORR that Resident A had severely de-compensated since she last worked in the facility. In addition, Resident A was not receiving the care she needed for her large bedsores. ORR, along with Lifeways Network Performance Supervision Supervisor and Provider Liaison, had a meeting with CCH Administrative Staff to discuss staffing barriers. ORR provided additional training to all direct care staff at the facility. ORR substantiated the allegations for Neglect Class II, and CCH submitted a corrective action plan to address the established violations.

During the exit conference with Tony Thomas, he stated that they now have a contract with Shirley Abby, Nurse, who visits the facility on a regular basis, and she will continue visiting until the wound is healed. Shirley Abby trains the direct care staff and observes them providing wound care. She is also available to answer questions, as needed. Tony Thomas agreed that CCH would submit a written corrective action plan to address the established violations.

ALLEGATIONS: Resident B was observed with bruising around her eyes and on her head. It is unknown how the bruising occurred.

On January 13, 2026, I observed Resident B to have a faint and small cut/ scrape on the right side of her eye (right) and a scrape on her nose. It was also noted that she had facial hair that needed to be shaved. When I attempted to speak to Resident B, she mumbled, and I could not understand what she was saying. Resident B appeared to be in a different condition than previously observed (I was able to interview her in the past).

Regarding the marks on Resident B's face, Jessica Nebelung stated she did not know what happened, as she was gone, but she later heard Resident B had fallen into her closet. According to Jessica Nebelung, Brianna Berry and Jeniya Broadus were the direct care staff on duty when the incident occurred. Jessica Nebelung looked for an incident report, but it could not be located.

As a part of this investigation, I reviewed the Office of Recipient Rights Summary Report and the following was noted: On January 5, 2026, ORR received a complaint and it was alleged that Resident B had large bruises around her eye and on her head, and the staff were unaware as to how it occurred. There were also concerns that the facility is short staffed and staff are unable to provide Resident B with the 1:1 staffing. A review of the staff schedule reflected that on January 3, 2026, and January 4, 2026, Shy Johnson, DCW, worked alone during the 2nd shift, due to staff calling into work. On January 6, 2026, ORR observed Resident B and she had light bruising around her eyes and forehead. ORR interviewed Jessica Neblung, who informed that she did not know what happened, an incident report was not completed, and medical care for the bruising was not obtained. ORR also interviewed Shy Johnson, DCW, who denied that Resident B fell during the weekend of January 3, 2026, and January 4, 2026. Angel Galindo informed ORR that she worked third shift with Tina Williams, DCW, on January 3, 2026 – January 4, 2026. Shy Johnson, DCW had worked the shift (2nd) before her. When she arrived, Resident B had the bruising on her face. Shy Johnson told Angel Galindo that she did not know what happened. Breanna Berry was also interviewed, and she reported to ORR that she was unsure how Resident B had bruised her face. Breanna Berry denied that she witnessed Resident B falling or having knowledge of her falling. ORR substantiated the allegations for Neglect Class II. CCH submitted a corrective action plan to address the established violations.

On March 5, 2026, Ashlee Griffes, ORR, informed me that the contract for CCH is on a provisional license and the residents would be relocated if the issues continued.

On March 6, 2026, I interviewed Brianna Berry, DCW. She stated that she remembered the incident. It was on a weekend, during the first week of January of 2026. She and Janiya Broadus were working together. Janiya Broadus was assigned to care for Resident B, and she had stepped out of the room to get a brief (it was in another room as they were in the process of switching resident bedrooms). Brianna Berry stated that she was assisting Resident A, and then heard Resident B yell, “help me, help me!” Brianna Berry stated that she then went and observed Resident B who did not fall on the floor but was leaning up against the closet door. Resident B’s face was up against the door. She stated that Resident B has very thin skin and bruises easily. After the incident, Brianna Berry noticed a little knot and a small gash above Resident A’s eye. Brianna Berry stated that Resident B was not crying and did not say that she was hurting. Brianna Berry stated that she really cared about Resident B and looked out for her. She stated she was not assigned to Resident B, so she didn’t know whether to contact 911 or management. She called Jessica Nebulung, but she didn’t answer. She stated the next day, Resident B’s face looked swollen and the gash looked larger. Brianna Berry stated that she got into trouble because she did not seek medical attention and later completed an Incident Report. Brianna Berry stated that Resident B started to decline about eight months ago and she has been that way ever since. In addition, she has good days but for the most part, she sleeps and just sits in her chair. Brianna Berry was very cooperative during the interview.

During the exit conference, I expressed concern regarding the number of allegations and complaints at this facility. I informed him that continued established violations could result in a recommendation for disciplinary action against the license. Tony Thomas voiced an understanding and agreed that CCH would submit a written corrective action plan to address the established violations.

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:	Regarding Resident A: Based upon my investigation, which consisted of an on-site investigation, interviews with Resident A, staff, administration, ORR, APS, and review of pertinent information, it's concluded that there is a preponderance of the evidence to support the allegations that while Resident A had a history of refusing services, following recommendations, and issues with her insurance, Resident A was not protected as she developed and was diagnosed with a Sacral Decubitus Ulcer, Stage II, despite an *Individual Plan of Service*, that required her to be repositioned every two hours to reduce her risk for development of decubitus ulcers and maintain skin integrity. Regarding Resident B: Based upon my investigation, which consisted of an on-site investigation, interviews with staff, administration, ORR, APS, and review of pertinent information, it's concluded that there is a preponderance of the evidence to support the allegations that Resident B was not provided with the supervision she required, as she was observed to have injuries to her face; despite requiring 1:1 dedicated staffing during the awake hours and 15-minute bed checks during the sleeping hours.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of a very detailed written corrective action plan, it's recommended that the status of the license remains unchanged.

Mahtina Rubritius 03/06/2026

Mahtina Rubritius Date
Licensing Consultant

Approved By:

Dawn Timm 03/09/2026

Dawn N. Timm Date
Area Manager