



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

April 16, 2026

Prabhjot Singh
Park Place OPCO LLC
PO BOX 1568
Portage, MI 49081

RE: License #: AL390418621
Investigation #: 2026A0581024
Park Place Senior Living B

Dear Prabhjot Singh:

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 black ink that reads "Cathy Cushman". The signature is written in a cursive, flowing style.

Cathy Cushman, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(269) 615-5190

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL390418621
Investigation #:	2026A0581024
Complaint Receipt Date:	03/13/2026
Investigation Initiation Date:	03/21/2026
Report Due Date:	05/12/2026
Licensee Name:	Park Place OPCO LLC
Licensee Address:	4218 S Westnedge Ave Kalamazoo, MI 49008
Licensee Telephone #:	(269) 329-8187
Administrator:	Prabhjot Singh
Licensee Designee:	Prabhjot Singh
Name of Facility:	Park Place Senior Living B
Facility Address:	4218 S Westnedge Ave Kalamazoo, MI 49008
Facility Telephone #:	(269) 329-8187
Original Issuance Date:	12/20/2024
License Status:	REGULAR
Effective Date:	06/20/2025
Expiration Date:	06/19/2027
Capacity:	20
Program Type:	PHYSICALLY HANDICAPPED AGED ALZHEIMERS

II. ALLEGATIONS

	Violation Established?
Resident A's room smells like urine.	No
Resident B's bathroom vanity cabinet is in disrepair.	Yes
Only male staff are available to assist Resident A with personal care; despite her assessment plan documents requiring assistance from female staff.	No
Resident A medications are not being administered, as required.	Yes
Direct care staff smoke marijuana while working.	No
Direct care staff refer to residents in a demeaning manner.	No
Direct care staff do not respond to residents' requests for assistance.	No
Direct care staff are not notifying Guardian A1 of Resident A's falls.	No

III. METHODOLOGY

03/13/2026	Special Investigation Intake - 2026A0581024
03/13/2026	Special Investigation Initiated – Telephone - Interview with Complainant.
03/13/2026	Contact – Telephone call made – Interview with Lyndsey Winfield, Milestone Corporate Compliance Officer
03/17/2026	Contact – Telephone call made – Attempted contact with Complainant.
03/19/2026	Contact – Telephone call made – Attempted contact with Complainant.
03/23/2026	APS Referral – made online.
03/24/2026	Contact – Document Received – Email from Complainant.
03/24/2026	Contact – Telephone call received – Interview with APS specialist, Melissa Pachota. Scheduled joint inspection.
03/25/2026	Inspection Completed On-site - Interview with staff and observed Resident A.
03/25/2026	Contact – Document Sent – Email to Isabelle Sanhou and Prabhjot Singh.

0/3/27/2026	Contact - Document Sent - Email to Isabelle Sanhou and Prabhjot Singh.
03/31/2026	Contact - Document Received - Email from Isabelle Sanhou, Executive Director.
04/06/2026	Contact - Telephone call made - Interview with Guardian A1.
04/09/2026	Contact – Telephone call made – Attempted contact with direct care staff, India Travis, Elom Agbaglo, Missehoun Komi "Mike" Alodjisso, and Jerlean Lewis.
04/09/2026	Contact – Telephone call made – Interview with Administrator and Licensee Designee, Prabhjot Singh.
04/09/2026	Contact – Telephone call received – Interview with Isabelle Sanhou.
04/09/2026	Contact – Telephone call made – Interview with Relative A1.
04/09/2026	Contact – Document Sent – Email correspondence with Dan Mueller, HomeTown Pharmacy long term care service coordinator.
04/10/2026	Contact - Document Received - Email correspondence with Guardian A1
04/10/2026	Contact - Document Received - Email correspondence with licensee designee, Prabhjot Singh, and executive director, Isabelle Sanhou.
04/10/2026	Inspection Completed On-site - Interviewed staff and residents.
04/10/2026	Contact – Telephone call received – Voicemail from India Travis.
04/13/2026	Contact – Telephone call made – Attempted contact with India Travis. She answered, but requested I call her back at a later time.
04/15/2026	Contact – Telephone call made – Interview with India Travis.
04/16/2026	Exit conference with the licensee designee, Prabhjot Singh.

ALLEGATION:

- **Resident A's room smells like urine.**
- **Resident B's bathroom vanity cabinet is in disrepair.**

INVESTIGATION: On 03/13/2026, Complainant contacted the Department to report concerns regarding Resident A's care in the facility, including physical plant issues. Complainant stated a strong urine odor was present in Resident A's bedroom, which was described as "unbearable." Complainant also stated mold was observed inside Resident B's bathroom vanity.

Complainant stated Resident A receives services through Milestone Senior Services and indicated that Resident A's guardian, Guardian A1, and Relative A1 could provide additional information regarding the allegations.

On 03/24/2026, Complainant provided a picture of Resident B's bathroom vanity, identified as located within bedroom #4. Complainant documented the photograph was taken on 03/12/2026 and staff were informed of the concern; however, no corrective action had been taken. Complainant further documented the vanity appeared to be leaking and that black mold was present within the cabinet.

I reviewed the photograph provided by Complainant. The bathroom vanity cabinet exhibited significant water damage and deterioration. The interior base and lower back panel showed dark staining, moisture damage, and apparent mold growth. The sides and bottom of the bathroom cabinet were not in good repair and not easily cleanable.

On 03/25/2026, I conducted an unannounced investigation at the facility with Adult Protective Services specialist, Melissa Pachota. We inspected Resident A's bedroom and bathroom and did not detect any urine odors in either space. Resident A's bedroom appeared clean, orderly, and free of foul odors, including urine.

We inspected Resident B's bathroom, which included her vanity. The condition of her vanity was consistent with the photograph provided by Complainant on 03/24/2026.

I interviewed direct care staff, Stephanie Shook, Shelley Simmons and Karojo Maturanyi, who all stated they were not aware of Resident B's vanity being in disrepair. They stated neither Resident B nor Resident B's family or visitors reported concerns regarding the cabinet.

Additionally, none of the staff interviewed identified concerns regarding urine odors in Resident A's bedroom. They stated Resident A's bedroom is routinely maintained in a clean and orderly condition. They indicated a temporary odor could occur if incontinent products were present in the room prior to disposal.

On 03/25/2026, I informed the licensee designee, Prabhjot Singh, and executive director, Isabelle Sanhou, of the condition of Resident B's bathroom vanity.

On 04/06/2026, I interviewed Guardian A1 who stated no current concerns regarding the condition of Resident A's bedroom within the past month. She stated the room is clean during her visits, noting she ensures its cleanliness.

On 04/08/2026, Prabhjot Singh stated Resident B's bathroom vanity was replaced within a day to two days after being notified. He stated he was previously unaware of the condition of the vanity, but would have addressed it sooner if he had been informed. Prabhjot Singh further stated he visits the facility at least weekly and has not observed or detected any significant or persistent urine odor in Resident A's bedroom.

On 04/09/2026, I interviewed Executive Director, Isabelle Sanhou, whose statement was consistent with other staff's statements.

APPLICABLE RULE	
R 400.647	Safety and maintenance of premises.
	(1) A facility must be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.
ANALYSIS:	<p>At the time of the inspection on 03/25/2026, no urine odors were detected in Resident A's bedroom. The room appeared clean and orderly, and there was no indication it was not being maintained in a manner that supports Resident A's health, safety, and well being</p> <p>However, the condition of Resident B's bathroom vanity was consistent with the allegation and the photograph provided by Complainant. The vanity exhibited significant disrepair, including water damage and apparent mold and/or mildew, which indicates the vanity was not maintained in a manner that adequately supports the health, safety, and well-being of Resident B. The licensee designee, Prabhjot Singh, stated on 04/09/2026 that the vanity was replaced shortly after he became aware of its condition on 03/25/2026.</p>
CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION: Only male staff are available to assist Resident A with personal care; despite her assessment plan documenting assistance from female staff.

INVESTIGATION: The complaint alleged the facility has shifts where only male staff are scheduled, despite Resident A's assessment and care plan documenting female staff should provide her personal care. The complaint further alleged Guardian A1 stays in the facility when only male staff are working.

Complainant documented that Resident A has limited ability to communicate and is mostly nonverbal. Complainant provided a copy of Resident A's Milestone Senior Services document titled *Assessment Report*, dated 11/10/2025, and *Person Centered Service Plan (PCSP)*, dated 11/10/2025. Review of the *Assessment Report* and PCSP did not indicate only female staff were required to assist Resident A with toileting or bathing.

Direct care staff Stephanie Shook stated there had been recent shifts where only male staff were identified as scheduled to work in the facility. She stated that during these instances, a female staff would either be mandated to work in the building or a brought from another building to assist with Resident A's personal care needs, including toileting and showering. She confirmed Resident A receives assistance from female staff for these tasks and stated she was not aware of any instances where male staff provided toileting or showering assistance to Resident A.

Direct care staff Shelley Simmons' statement was consistent with Stephanie Shook's statement. She stated if she were aware of only male staff being scheduled to work in the facility then she would either stay over to work or come into the facility to address Resident A's personal care needs.

Direct care staff Karojo Muturanyi's statement was consistent with other staff's statements. He stated that when only male staff are scheduled, arrangements are made for female staff from other buildings to assist. He denied providing toileting or showering assistance to Resident A and was not aware of any other male staff providing this type of personal care.

Resident A was not interviewed during the inspection due to her being nonverbal. Resident A appeared clean and well cared for.

On 03/26/2026, Isabelle Sanhou provided staff schedules from 02/15/2026 through 04/11/2026. Review of the scheduled showed that only male staff were scheduled on 2/22, 03/03, 03/21, 03/22, 04/03, and 04/09 for second shift.

I reviewed Resident A's *Resident Care Agreement (RCA)*, dated 08/21/2025, which documented Guardian A1's agreement that Resident A may receive assistance in bathing, dressing, or personal hygiene by a staff member of the opposite sex, if a same sex staff member is not available.

I also reviewed Resident A's assessment plan completed by the licensee, dated 01/22/2026, which documented Resident A was not to receive assistance by the opposite sex. The assessment plan further documented that only female staff are to provide toileting and showering assistance.

Guardian A1's statement was consistent with the allegation. She stated that male staff are not to toilet, shower, or dress Resident A, as documented in the assessment and care plans. She stated she reviewed staff schedules and observed shifts where only male staff were scheduled, primarily on second shift. She stated that on those occasions, she remained overnight at the facility to ensure male staff did not provide personal care. Guardian A1 further stated she personally provided Resident A with toileting, showering and dressing assistance during those times.

Guardian A1 also stated she installed a camera in Resident A's bedroom; however, she did not indicate observing male staff providing any type of personal care to Resident A.

Licensee designee Prabhjot Singh stated Guardian A1 reported her concerns regarding instances when only male staff were scheduled to work. He stated he spoke to Isabelle Sanhou, who indicated that although male staff were scheduled, they were not providing toileting, showering, or dressing assistance to Resident A. He stated that, when needed, a female staff would be brought in from a neighboring facility to provide personal care assistance, a male staff would switch with a female staff, or Isabelle Sanhou would report to the facility to provide care.

Isabelle Sanhou's statement was consistent with Prabhjot Singh's statement. She denied any male staff providing personal care to Resident A.

On 04/09/2026, I interviewed Relative A1. She stated there had been instances during her visits when two male staff were present and she did not observe a third staff or a female staff; however, she acknowledged she did not ask whether a female staff was available. She stated that during these instances she remained present and would assist Resident A with toileting or changing, if needed.

Relative A1 described one occasion in which two male staff were in the room with Resident A but were not providing personal care and were only checking on her. She stated Resident A remained clothed, and Relative A1 was not concerned that male staff were providing personal care. Relative A1 further stated she did not confirm whether a female staff was available in the facility. She stated Guardian A1 informed her the facility can bring a female staff from another building to assist when needed.

On 04/10/2026, I interviewed direct care staff Tristan Sigsbee who stated she had not observed or been present during any instance in which male staff provided toileting or showering assistance to Resident A.

On 04/10/2026, I interviewed Residents C, D, and E. None of the residents reported knowledge of instances where only male staff were working or where male staff provided personal care to Resident A.

APPLICABLE RULE	
R 400.671	Resident care.
	(1) Staffing shall be sufficient to meet the needs of the residents in accordance with each resident's assessment plan and individual plan of service.
ANALYSIS:	<p>Based on my investigation, which include interviews with multiple direct care staff, licensee designee Prabhjot Singh, executive director Isabelle Sanhou, Guardian A1, Relative A1, a review of the facility's staff schedules and relevant AFC documentation, Resident A's assessment plan documented female staff are to assist Resident A with toileting, showering and dressing; however, on several occasions only male staff were scheduled to work in the facility during second shift.</p> <p>Despite only male staff being scheduled to work in the facility, there is no supporting evidence that male staff provided Resident A's personal care as staff reported female staff would be brought in from another building, female staff would be called in to work, schedules would be adjusted, or Guardian A1 or Relative A1 would be present to provide such care to Resident A.</p> <p>Subsequently, based on the available information, there is insufficient evidence to support that staffing was not sufficient to meet Resident A's needs in accordance with her assessment plan.</p>
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION: Resident A medications are not being administered, as required.

INVESTIGATION: The complaint alleged Resident A's medications were not administered as prescribed, including concerns that she was given medications that were no longer needed, specifically Lidocaine patches. Additionally, it was alleged Resident A was administered Lidocaine patches that remained in place for 24 hours, rather than the prescribed 12 hour duration.

On 03/24/2026, I reviewed documentation provided by Complainant indicating that in December 2025, Resident A did not receive her Memantine medication, prescribed for dementia, for at least 10 days. Complainant provided emails from Guardian A1 which included a photograph of Resident A's medication list showing a handwritten notation next to the Memantine indicating it was "missing". Complainant documented Guardian A1 reported the missing medication to Isabelle Sanhou.

Direct care staff Stephanie Shook and Karojo Muturanyi provided consistent statements. They both stated they administer medications to Resident A and are familiar with her regimen. Neither staff stated any current concerns with how Resident A's medications are administered. They both stated Resident A was prescribed Lidocaine patches as a PRN, or as needed basis; however, she had not required or received the patches for approximately two months. Stephanie Shook stated the patches were to be applied at night and removed in the morning, with staff being prompted by the electronic Medication Administration Record (eMAR).

Stephanie Shook stated Resident A's Memantine medication was discontinued on 03/20/2026. She stated the medication had run out in December due to not being refilled in a timely manner and that she subsequently ordered a refill. She stated she was unsure how long Resident A had been without the medication. Karojo Muturanyi was unable to provide additional information regarding Resident A's Memantine.

Shelley Simmons stated she does not administer medications in the facility and therefore had no information regarding the allegations or Resident A's medications.

During the inspection, I reviewed Resident A's March eMAR. According to my review, Resident A's Memantine medication was discontinued on 03/20/2026. The eMAR also listed four PRN medications: Megestrol Acet 40 mg/ml susp, Ibuprofen 600 mg, Acetaminophen 500 mg, and Lidocaine 4% patch; however, the Ibuprofen 600 mg, Acetaminophen 500 mg, and Lidocaine 4% patch were not present in the medication cart or elsewhere in the facility. Stephanie Shook stated Guardian A1 had taken these medications and not returned them. Based on my review of the medication cart, Resident A's Ibuprofen, Acetaminophen, and Lidocaine patches were not available in the cart to administer.

Guardian A1 stated Resident A stayed with her for multiple days in December because she transported her to multiple out of town medical appointments on or around 12/10/2026. She stated the facility staff provided Resident A's medications and eMAR so she could administer medications while away from the facility; however, she stated Resident A's Memantine medications was not provided for the trip. Guardian A1 stated she contacted Isabelle Sanhou regarding the issue who confirmed the medication was not in the facility.

Guardian A1 also identified discrepancies in the eMAR, indicating the medication appeared to be missed for several days, then administered, and then unavailable again. Subsequently, Guardian A1 stated Resident A did not receive the Memantine

medications for approximately 10 days because it was not available to be administered.

Guardian A1 stated there were additional concerns regarding Resident A's Lidocaine patch administration in the facility. She indicated Resident A had two separate Lidocaine patch orders – one upon admission and another following a November Emergency Room (ER) visit related to a fall. Guardian A1 stated that after the ER visit, the additional prescription was sent to a local pharmacy, which she picked up the following morning and delivered to the facility.

Guardian A1 indicated there was confusion regarding administration instructions, as the pharmacy directed the patch to be applied in the morning, while the facility's scheduled order indicated application at night. She further stated that during the ER visit, a Lidocaine patch had been applied to Resident A's back, which contributed to the confusion. Although she later clarified the instructions with Isabelle Sanhou, Guardian A1 stated there were multiple instances in December where Resident A wore a Lidocaine patch for approximately 24 hours at a time.

Guardian A1 confirmed she was in possession of Resident A's Lidocaine patches, Ibuprofen and Acetaminophen prescriptions.

Prabhjot Singh stated Guardian A1's concern with Resident A's Lidocaine had been resolved, noting there appeared to be discrepancies among multiple physicians or pharmacists involved in Resident A's care. He did not believe or have any knowledge regarding the Lidocaine patches being left on Resident A's back for 24 hours a duration.

Prabhjot Singh confirmed Resident A's Memantine medication was discontinued. He stated refill requests for the medication were submitted to the HomeTown Pharmacy on 10/21, 11/28, 12/10, and 1/12. He initially was unable to explain why the medication was not received by the facility or why Resident A was without this medication for approximately 10 days; however, he later provided documentation confirming the Memantine medication prescription on 12/15 was completed by Resident A's new physician rather than her previous prescribing physician. Prabhjot Singh further documented it takes approximately two weeks for new provider to issue updated prescriptions to the pharmacy, which he believed contributed to the delay in medication being available to the facility.

Isabelle Sanhou's statement was consistent with Prabhjot Singh's statement. She acknowledged an understanding that the Lidocaine patch should be applied for 12 hours and removed for 12 hours. Isabelle Sanhou was not aware of Lidocaine patch being left on for 24 hours at a time. She stated the medication was initially scheduled and later changed to a PRN. Isabelle Sanhou further stated Guardian A1 later requested staff not administer the Lidocaine; however, she advised Guardian A1 the medication must remain available in the facility and administered as ordered until a discontinuation order was obtained from the physician.

Isabelle Sanhou also stated Guardian A1 did not want staff administering the Lidocaine patches to Resident A and subsequently removed them from the facility approximately one month prior. She further indicated Guardian A1 required staff to obtain permission before administering PRN medications, which created difficulty for staff in administering Resident A's PRN medications.

Isabelle Sanhou also stated there were delays by Resident A's physician in submitting refill orders for Memantine. She further stated concerns with staff documenting medications as "not in the facility" when the medications were present but not located.

I reviewed Resident A's December eMAR, which documented an active order for Memantine HCL 5 MG tablet, to be administered orally at bedtime. According to the December eMAR, the medication was not administered on 12/01, 12/02, 12/04, 12/12, 12/13 or 12/14 because it was not in the facility. On 12/10, the eMAR documented Resident A refused to take the medication, with the notation "off med".

Additionally, the December eMAR documented two Lidocaine patch orders:

- A Lidocaine patch with instructions to apply one patch every 12 hours for pain. This order had a start date of 12/05/2025 and an end date of 12/18/2025. The eMAR reflected administration on 12/14 and 12/18.
- A Lidocaine 4% patch with instructions to apply one patch topically in the morning and remove at bedtime. This order had a start date of 12/18/2025 and an end date of 02/10/2026. The eMAR reflected no administrations during December.

I reviewed Resident A's January and February eMAR, which did not identify any concerns related to the administration of Memantine. Additionally, no Lidocaine patches were administered during either month.

On 04/09/2026, HomeTown Pharmacy Long Term Care Service Coordinator, Dan Mueller, documented Resident A's Memantine 5mg prescription was originally filled on 9/22/2025 for a 30 day supply. He stated refill requests were documented on 11/28/2025 and 12/11/2025; however, no refills remained, and a new prescription was required. He documented this was communicated with the facility via fax and an electronic request was sent to the prescriber. He documented a new prescription was not obtained until 12/15/2025, at which time the medication was filled and administration resumed.

Prabhjot Singh provided eMAR documentation and refill requests records for Resident A's Memantine, which was consistent with the information provided by Dan Mueller.

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:	<p>Despite interviews with multiple direct care staff and Guardian A1, I am unable to determine whether staff administered Resident A's Lidocaine patch and left the patches in place for 24 hours at a time. Staff interviews indicated they were aware the patch should be applied for 12 hours and removed for 12 hours. Subsequently, there is insufficient evidence to determine a violation that Resident A's Lidocaine patches were not administered as prescribed.</p> <p>Alternatively, based on my investigation, HomeTown Pharmacy was unable to refill Resident A's Memantine prescription due to the need for a new order from Resident A's physician. Documentation provided by the licensee shows that Resident A changed physicians, and a new prescription was issued on 12/15/2025, and was subsequently filled, allowing the medication to be administered. However, a review of Resident A's December 2025 eMAR shows the scheduled Memantine HCL 5 MG tablet was not administered on 12/01, 12/02, 12/04, 12/12, 12/13 or 12/14 due to the medication not being available in the facility. Consequently, Resident A's Memantine medication was not available to be administered in December 2025 as prescribed.</p> <p>Additionally, during the inspection on 03/25/2026, Resident A's PRN medications, including Ibuprofen 600 mg, Acetaminophen 500 mg, and Lidocaine 4% patch were not present in the facility. The executive director, Isabelle Sanhou, stated Guardian A1 removed the medications because she did not want staff administering them. As a result, these medications were not available to be given to Resident A, as prescribed.</p>
CONCLUSION:	VIOLATION ESTABLISHED

ALLEGATION:

- **Direct care staff smoke marijuana while working.**
- **Direct care staff refer to residents in a demeaning manner.**
- **Direct care staff do not respond to residents' requests for assistance.**

INVESTIGATION: The complaint alleged direct care staff smoke marijuana in the facility, refer to residents in a demeaning manner in the presence of visitors, and fail to respond to residents requesting assistance.

On 03/24/2026, Complainant clarified that Resident C was heard yelling for assistance from her bedroom on or around 03/03/2026 by Relative A1. Complainant documented Resident C was again heard yelling for assistance on 03/04/2026, which was reportedly videotaped by Guardian A1. Complainant further documented that on or around 03/06/2026, Relative A1 overheard direct care staff, identified as India Travis, refer to Resident C and Resident D as the "the crazies".

Direct care staff Stephanie Shook, Shelley Simmons, and Karojo Muturanyi all denied having any firsthand knowledge of staff smoking marijuana in the facility or being aware of staff being under the influence of marijuana while working.

Shelly Simmons stated that, at times, staff have arrived at work smelling like marijuana; however, she did not have reason to believe those staff were under the influence while on duty. All staff interviewed denied smoking marijuana while working and denied failing to assist residents when assistance was required.

Shelley Simmons described an instance in which she asked staff, India Travis about Resident C, and India Travis reportedly responded, "who, crazy [Resident C]?". Shelley Simmons stated no other individuals were present during this exchange. She further stated that Resident C will, at times, call out for assistance without an apparent need. She indicated that if staff are assisting another resident at the time, Resident C may need to wait for assistance.

Prabhjot Singh and Isabelle Sanhou provided consistent statements. Both denied knowledge of staff smoking marijuana, being under the influence while working, or referring to residents in a demeaning manner.

Isabelle Sanhou acknowledged that staff occasionally arrive to work smelling like marijuana, which she attributed to the staff's prior environment before reporting to work. She stated that when she becomes aware of this, she addresses it directly with that staff.

Relative A1's statement was consistent with the allegations and what was reported by Complainant. She stated she has smelled marijuana in the facility, but never

observed staff using it. Relative A1 statement regarding staff referring to residents in a demeaning manner was consistent with the allegations. She stated she was present in the facility's dining room when she overheard staff, India Travis, refer to Resident C and Resident D as "the two crazies". Relative A1 stated the comment was not directed to her but was made in her presence. She indicated she did not believe Resident C, Resident D, or any others heard the comment. Relative A1 described the statement as inappropriate.

Additionally, Relative A1 stated on or about 03/03/2026, she heard Resident C yelling and calling out for assistance from her bedroom for approximately 10-15 minutes. She stated Resident C was yelling for help while staff were present in the facility but appeared not to respond. Relative A1 further stated that Guardian A1 had a video of Resident C yelling for assistance on the following evening.

On 04/10/2026, Guardian A1 forwarded two videos, one lasting 40 seconds and the other lasting 41 seconds. The 40 second video depicted a hallway with a resident walking. Throughout the video, banging could be heard, along with a person repeatedly stating, "help", "I need help", "help me" and "please help me". The individual also repeatedly stated "please". The video identified neither the source of the banging sound nor the individual requesting assistance.

The 41 second video also depicted a hallway, with a male staff near the end of it. Banging could be heard throughout the video; however, I was unable to determine the source of the noise. Guardian A1 indicated in her email that Resident C bangs her hairbrush to create noise in an attempt to gain staff attention and assistance, but reported she is frequently ignored.

On 04/10/2026, I interviewed Residents C, D, and E regarding the allegations. None of the residents had any information regarding staff smoking marijuana in the facility.

During my interview with Resident C, she appeared very agitated. She stated staff do not assist her and reported she needs help with most tasks. She was unable to specify how long she typically waits for staff assistance. Resident C acknowledged she can be difficult to assist at times. She stated she is able to alert staff when she needs assistance; however, she stated this does not always result in timely help. I remained with Resident C for approximately five minutes and offered to obtain staff assistance after she indicated she needed help; however, she declined. Direct care staff, Tristan Sigsbee, entered the room after approximately five minutes and assisted Resident C with sitting in her sit to stand recliner. My observations of staff interaction with Resident C appeared appropriate. Due to Resident C's agitation, I was unable to obtain information regarding how staff speak to her or other residents.

Resident D stated staff assist her when needed, but they encourage her to complete tasks independently, which she reported causes her frustration. She stated staff will remind her that she has previously completed similar tasks and encourage her to try

on her own. Resident D did not report any concerns regarding staff using demeaning language toward her.

Resident E stated staff are generally present and available to assist when needed. He stated staff are not always immediate in responding; however, he acknowledged there are multiple residents throughout the facility requiring assistance. Resident E stated staff do assist residents, including Resident B, although he described Resident C as sometimes being grumpy or rude toward staff. Resident E denied awareness of staff referring to Resident C or Resident D in a demeaning manner.

Tristan Sigsbee's statement regarding staff smoking marijuana, referencing residents in a demeaning manner and assisting residents in a timeliness of assistance were consistent with other staff interviews.

On 04/15/2026, I interviewed former direct care staff, India Travis. Her statement regarding staff smoking marijuana was consistent with other staff interviews. She stated she assisted residents when needed. India Travis stated Resident C had a prior leg surgery on her leg that resulted in swelling and limited ability to sit or stand for extended periods. She stated Resident C often requested assistance by yelling for staff and banging on objects while doing so. India Travis stated that if staff were not immediately available, Resident C would continue yelling statements such as "you're not helping me" and "help". She indicated Resident C was typically assisted within a reasonable time frame, generally less than 15 minutes.

India Travis stated Shelley Simmons did not always promptly respond to Resident C; however, she also stated Resident C expressed that she did not want assistance from Shelley Simmons.

India Travis acknowledged referencing Resident C as "the crazy one", but stated this comment was made to Shelley Simmons in a private conversation and denied every making that type of comment in front of any visitors. She stated this reference was based on Resident C's frequent yelling and screaming for assistance. India Travis denied using such language directly toward Resident C. She stated she developed a good working relationship with Resident B after becoming familiar with her behaviors.

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:	<p>Based on my investigation, there is no supporting evidence that direct care staff were smoking marijuana in the facility or were under the influence while providing care to residents.</p> <p>Although former staff, India Travis, acknowledged referring to Resident C as “the crazy one”, she stated this statement was made in a private conversation and not directed toward Resident C. There is no supporting evidence this comment was made in the presence of residents or visitors or that residents were subjected to demeaning language. Additionally, India Travis is no longer employed at the facility.</p> <p>Furthermore, there is no supporting evidence that staff failed to treat residents with dignity and respect or failed to provide protection and safety by responding to their requests for assistance. While video evidence documented a resident repeatedly calling out for help, this was consistent with staff statements and observed behavior of Resident C, including frequent vocalizations and use of noise to gain attention. Observations during the inspection indicated staff interactions with residents were appropriate.</p>
CONCLUSION:	VIOLATION NOT ESTABLISHED

ALLEGATION:

Direct care staff are not notifying Guardian A1 of Resident A’s falls.

INVESTIGATION: The complaint alleged direct care staff did not notify Guardian A1 when Resident A experienced falls.

Direct care staff Stephanie Shook, Shelley Simmons, and Karojo Muturanyi all stated incident reports were completed when Resident A experiences a fall and that Guardian A1 is notified.

Isabelle Sanhou provided five Incident Reports (IRs) completed for Resident A since residing in the facility since September 2025, dated 09/26, 10/25, 10/28, 01/20, and 03/06, which documented the following:

- 09/26: IR documented Resident A sustained a burn while eating. Corrective actions included use of a bib and one to one feeding.
- 10/25: IR documented Resident A fell and struck her head on a table. Staff applied ice and contacted Resident A’s provider and Guardian A1. Increased monitoring and one to one time were implemented.

- 10/28: IR documented Resident A was sent to a local hospital due to facial and eye swelling.
- 01/20: IR documented Resident A fell in the hallway near the bathroom while staff were in the medication room. Resident A sustained a scrape to the right side of her forehead. Staff applied a head protector and placed her in a recliner.
- 03/6: IR documented Resident A fell from a recliner in the living room while staff were in the medication room. No injuries were documented.

Review of the IRs indicates incidents were documented, corrective actions were identified, and Guardian A1 was notified, as indicated in the records.

Guardian A1 stated she did not receive copies of the incident reports relating to Resident A's falls; however, she acknowledged being aware of Resident A falls in October 2025 and more recent incidents. She expressed concern that Resident A has been falling more frequently. Guardian A1 also acknowledged awareness of Resident A's hospitalization in October for further evaluation following a "major contusion" sustained from a fall. She stated that medical professionals determined Resident A also sustained a wrist fracture from the fall.

Licensee designee Prabhjot Singh stated he was aware of Guardian A1's concern relating to Resident A's falls. He stated Resident A appears unsteady on her feet at times and is able to wander throughout the facility. He stated recommending use of a wheelchair for periods of rest; however, Guardian A1 opposed this recommendation due to concerns it may impact Resident A's ability to ambulate.

Isabelle Sanhou's statement was consistent with other staff and Prabhjot Singh's statements. She stated recommending that Resident A obtain a physician's order for a geri chair to help reduce falls, as Resident A tends to fall backward while ambulating. She further stated Resident A frequently wanders throughout the facility and appeared to become fatigued, which may contribute to her falls. Isabelle Sanhou indicated a wheelchair or geri chair may assist in reducing these incidents.

Isabelle Sanhou stated she and staff have notified Resident A's responsible agency, Milestone, and Guardian A1 when falls have occurred and have provided incident reports, although not required. She reported multiple conversations have taken place regarding Resident A's increased frequency of falls. Additionally, Isabelle Sanhou stated Guardian A1 instructed staff to send Resident A to the emergency room after a fall when swelling was observed. It was later determined that Resident A sustained a wrist fracture. Isabelle Sanhou stated she was not initially aware of the fracture but indicated the issue was subsequently addressed.

APPLICABLE RULE	
R 400.693	Incident notification, incident records.
	<p>(1) If a resident has a representative identified in writing on the resident's care agreement, a licensee shall report to the resident's representative within 48 hours after any of the following:</p> <ul style="list-style-type: none"> (a) Unexpected or unnatural death of a resident. (b) Unexpected and preventable inpatient hospital admission. (c) Physical hostility, self-inflicted harm, or harm to others resulting in injury that requires outside medical attention or law enforcement involvement. (d) Natural disaster or fire that results in evacuation of residents or discontinuation of services greater than 24 hours. (e) Elopement from the facility if the resident's location is unknown.
ANALYSIS:	<p>Pursuant to R 400.693(1), a licensee is required to report to a resident's representative within 48 hours only for specific incidents including unexpected or unnatural death, unexpected and preventable inpatient hospital admission, injury requiring outside medical attention or law enforcement involvement, natural disaster or fire resulting in evacuation, or disruption of services and elopement.</p> <p>Falls, in and of themselves, are not identified as reportable incidents under this rule unless they result in one of the specified outcomes. Review of the incident reports and staff interviews indicate that falls were documented, and in all instances, Guardian A1, was notified. Additionally, Guardian A1 acknowledged awareness of multiple fall incidents, including those resulting in medical attention.</p> <p>Subsequently, there is insufficient evidence the licensee did not comply with incident notification to Guardian A1.</p>
CONCLUSION:	VIOLATION NOT ESTABLISHED

On 04/16/2026, I conducted the exit conference with the licensee designee, Prabhjot Singh. He agreed with all the findings, except the violations pertaining to Resident A's medications, including Resident A's Memantine not being in the facility in December. Prabhjot Singh stated facility staff requested a refill of the Memantine; however, he agreed the change in Resident A's physicians held up the medication from getting refilled in a timely manner. Additionally, Prabhjot Singh stated he did

not agree with being cited for Resident A's PRN medications not being available in the facility because Guardian A1 took them. He indicated the facility's staff had limited control over this circumstance. I discussed with Prabhjot Singh that addressing a change in physician at the time a resident is admitted may assist a smoother transition in medication refills. I also discussed contacting APS when guardians take medications or immediately contact the prescribing physician to obtain a discontinued order. Overall, I stressed the importance of staff documenting their contacts with physicians and anything related to a resident's medications or health.

IV. RECOMMENDATION

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

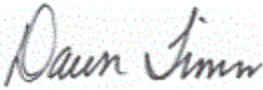


04/16/2026

Cathy Cushman
Licensing Consultant

Date

Approved By:



04/16/2026

Dawn N. Timm
Area Manager

Date